State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 17, Year 1998 **Physician** Maida Clydesdale Best 3:45 am /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glade Valley Nursing Home Walkersville Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) April 22, 1907 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Days 1 M 2 W F 91 Yrs. 214-30-5619 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Llmits MD Carroll Westminster Director 1 ☐ Yes 2 M No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2112 Sykesville Road 21157 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Paul G. Miller Clydesdale 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Louis Alton Best, son 10120 Greensward Link, Ijamsville, MD 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 05/19/98 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Emory Church Cemetery 4 ☐ Donatton 5 ☐ Other (Specify) Upperco, MD 21. Signature of Funeral Service Licensee 22. Progretad with the Will Home & Chapel 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Severe Dementia, Altzheimens Immediate Cause (Final disease or condition resulting in death) Arterioscleratic Cardiovascular Disease Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown by Be Completed 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 N No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of tnjury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyaiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifique 29c. License number 29d. Date signed (Month, Dey, Yeer) D21944 - my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9th Street, Frederick, Md. 21701

State Registrar

Funeral

Director

7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

"natural",

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any Injury or other traumatic events

Physician

/Medical

Examiner

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page 2

certificate

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I Director: After this certificated in by the funerel director, pa

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P.O. Box 68760

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Division of Vital

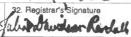
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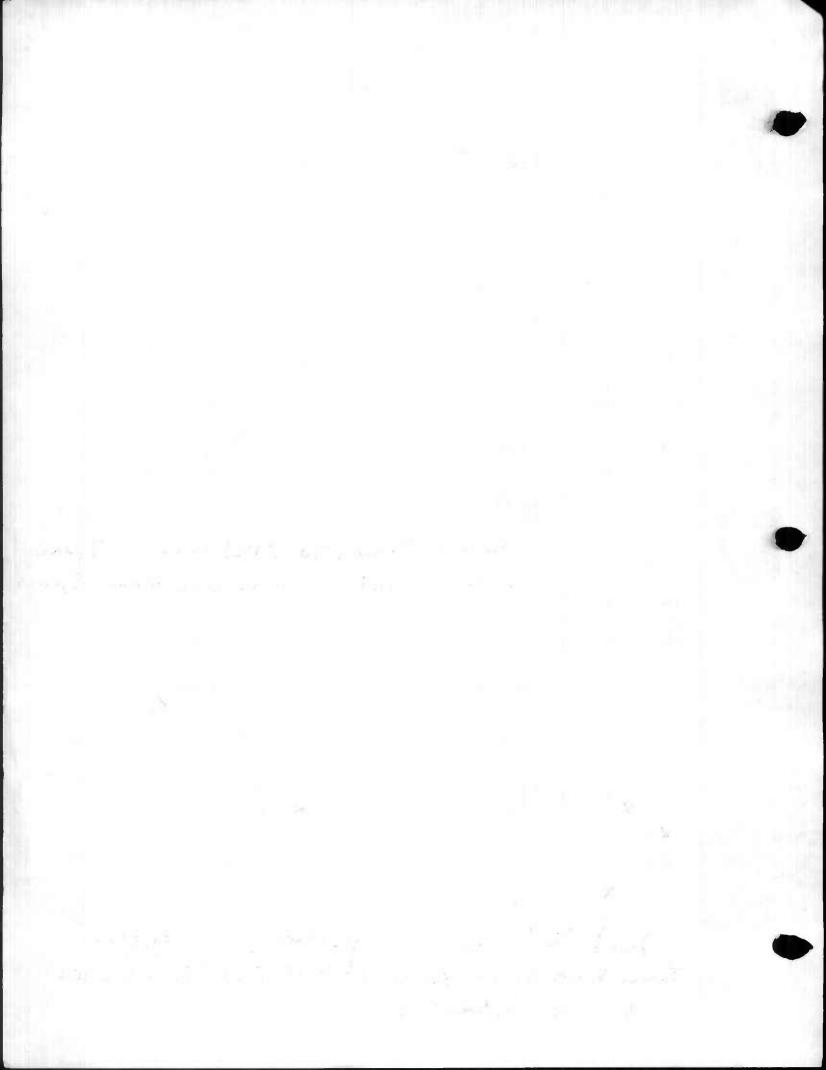
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death

Baltimore, Maryland 21215-0020

31. Date filed (Month, Day, Year) MAY 1 8 1998



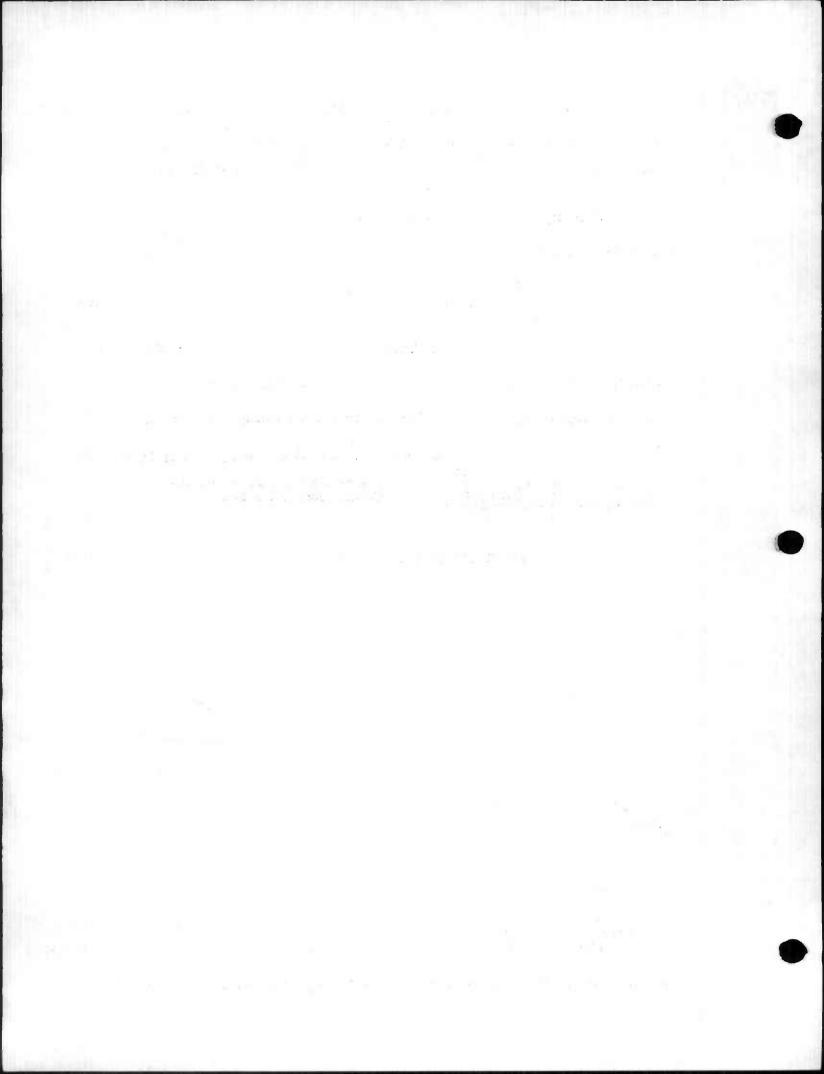


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State of Maryland / Department of Health and Mental Hygiene

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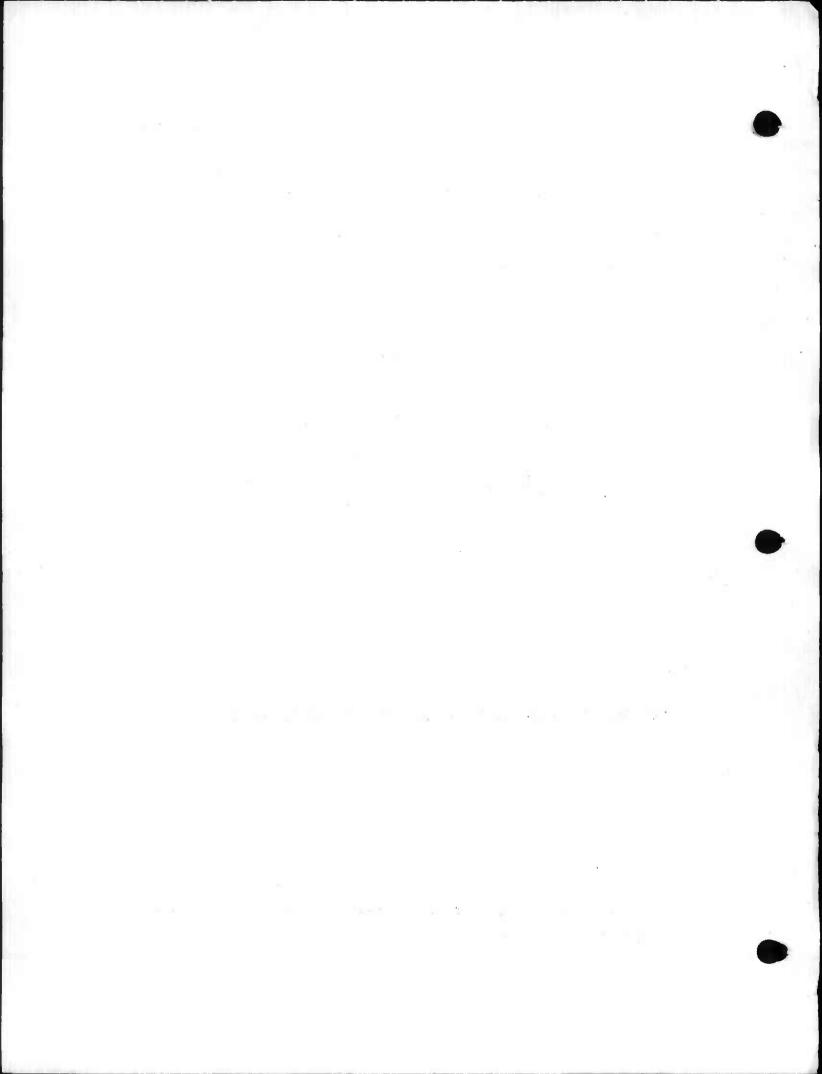
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i, MARYI be retained by ge 5 should be	be notified		Patricia	,	er-niece			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11830 Daniel Drive LaVale MD 21502									
may or, pa	nst b		20a, METHOD OF DISPOSIT	on 3 🗌 Rem	oval from Stata				OF DISPOS				DAT		CATION -		
MC age 6 direct	E	∦	1 Paurial 2 Crametion 3 Removal from Stata Camelery, cremetory, or other place) 4 Donation 5 Other (Specify) Rose Hill Cemetery 05/20 Cumberland MD 21502 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													MD 21502	
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.	examiner must		· YLCh	las	110	ud				Scar	pell erla	i Fu nd M	nera D 21				
Burs after in by the	medicai		Cumberland MD 21502 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, ahock, Dr heart fellura. List only one cause Dn each line. Approximate interval Batween														
ely filled nation, or	event, the m	IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) a. Cerebrocacular Academy DUE TO (OR AS A CONSEQUENCE OF):													Onset and Daeth		
o.O. BOX 68 to certificate be execunding physician and Hygiene prior to bur	or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.															
CORDS ires that the d signed by the tealth and Me	ws any Inju		PART II. Other algoritics Permi	A Pu	grant		ut not re	eaulting	In the ur	derlyln	g cause	given in	Part I.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
- > D =	23 st		DID TOBACC	O USE	CONTRIBUT	E TO	CAU	SE OI	DEA	TH Y	YES [] NO					
VITAL AN: The lan tificate has e State Dep	SICIAN:		25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:				OTHE		ACE OF D	EATH (Ch	eck only o	ne)			
F VIT.	2 2		1 TYES 2 NO		1 Inpatiant 2		etient 3		4 (SQNur	alng Hom		aldence		er (Specify)			
O 뜻 를 출	marked, or	- 69		Pending Investigation	28a. DATE Of (Month, L			28b. TIN	IE OF JURY M		URY AT PRK? YES 2	NO	26d, DE	SCRIBE HOW I	NJURY OCC	CURED	
ISI TTEN TTOR: after	28 E			Could not be datarminad	28a, PLACE (building,	OF INJURY , atc. (Spec	— At hor	na, farm,	street, fac	ory, offic	a		28f. LOC City	CATION (Street a or Town, State)	nd Number	or Rural Ro	outa Number,
DIV HOSPITAL OR A FUNERAL DIREC within 72 hours	T: It item		one)		CIAN: To the best of a												and manner as stated.
FUN	TANT		29b. SIGNATURE AND TITYE									ENSE NUR					(Month, Day, Year)
TO THE HOSPITAL TO THE FUNERAL De filed within 72	TO BE CO		18	Man	un	05.00						-14	_		N 4	IAY	17,1998
· · · 8.	1		Dr. Robust							. Me	d. B	lda.	Cım	berlan	d MD	2150	12
MAL A		1	31. DATE FILED (Month, Day,		ABGISTA			4	-J-P								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Day Month Physician MAY 18, 1998 /Medical EVELYN MYRTLE BAKER 5:08A.M. 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. Hours Min. If Undar 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Davs 1 □ M 2 🗓 F Director 162-16-2820 83 AUGUST 17 1914 PA Usual Rasidanca of Dacedant the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits must be notified at Director N Yes 2 No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? ò Items 23a 915 BEDFORD STREET 21502 Funeral U.S.A. 12. Was Dacadent Evar in U.S. Armed Forcas? 13. Was Dacedant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, Black, Whita, atc. hours after 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yes & No Specify: Specify: WHITE by 3 Widowed 4 □ Divorced Yaer or Dates: Completed Decedant's Usuat Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Bustnass/Industry filed within 72 Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) HOUSE KEEPER HOUSE KEEPER is marked other permit. Peges 1 and 2 should be file Department of Health and Maniel Hy Important: If Item 27 is marked oths any injury or other traumatic event 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be ROY EARL CLARK SR. NELLIE BROWN 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Bural Route Number, City or Town, State, Zin Code) D. JAMES BAKER 402 WARWICK AVE CUMBERLAND MARYLAND SON 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata SUNSET CEMETERY MAY 21 1998 4 ☐ Donation 5 ☐ Othar (Spacify) CUMBERLAND MARYLAND tura of Funaral Sarvica 22. Nama and Addrass of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND Approximeta Interval Between Onset end Death 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of **Physician** /Medicai Immediata Causa (Final Pneumococcal Bacteremia 7 days diseasa or condition rasulting in daath) Examiner Dua to (or as a consequance of) Examiner requires that the death certificate be executed Sequantially list conditions, if eny, taading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiatad avants rasulting in daath) Last end Dua to (or as a consequence of) physician e Box 68760, Physician/Medical the Dua to (or as a consequence of) for use es use es Records, P.O. Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Pneumonia þ 24b. Wara autopsy findings eveileble prior to complation of cause of death? Completed 24a. Was en eutopsy performed? Pulmonary Hypertension certificate hes director, page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ NO Vital Be 25. Was casa ratarred to madical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Division of this 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After Hospital or Attanding To the Hospital ...

within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 ☐ Suicida 6 Could not ba 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medicai (Check only one) title of certifier 29b. Signature at 29c. Licansa number 29d. Data signed (Month. Dav. Year) D 14865 Zm 1998 30. Nama and address of person who computed causa of daath (Itam 23a) (Type, Print)

YELD

217-28-9025

EVELYN BAKER

State State Registrar NAY 1 9 1998

R. BARRERA

MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MARYLAND 21502



certificate

this funeral

After

filled in by

Medicai

29e. Cartifier

(Check only one)

29b. Signeture and title of cartifier

death.

or Attand after death Director:

vithin 24 hours at To the Funeral D completely filled in

Division of Vital

Completed Be 2 Certification:

24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Limited 1 Yes 2□ No 17 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home SOResidence 6 Other (Specify) 1XX es 2 □ No 1 ☐ fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

State Registrar MD

29c. License number O.C.M.E

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

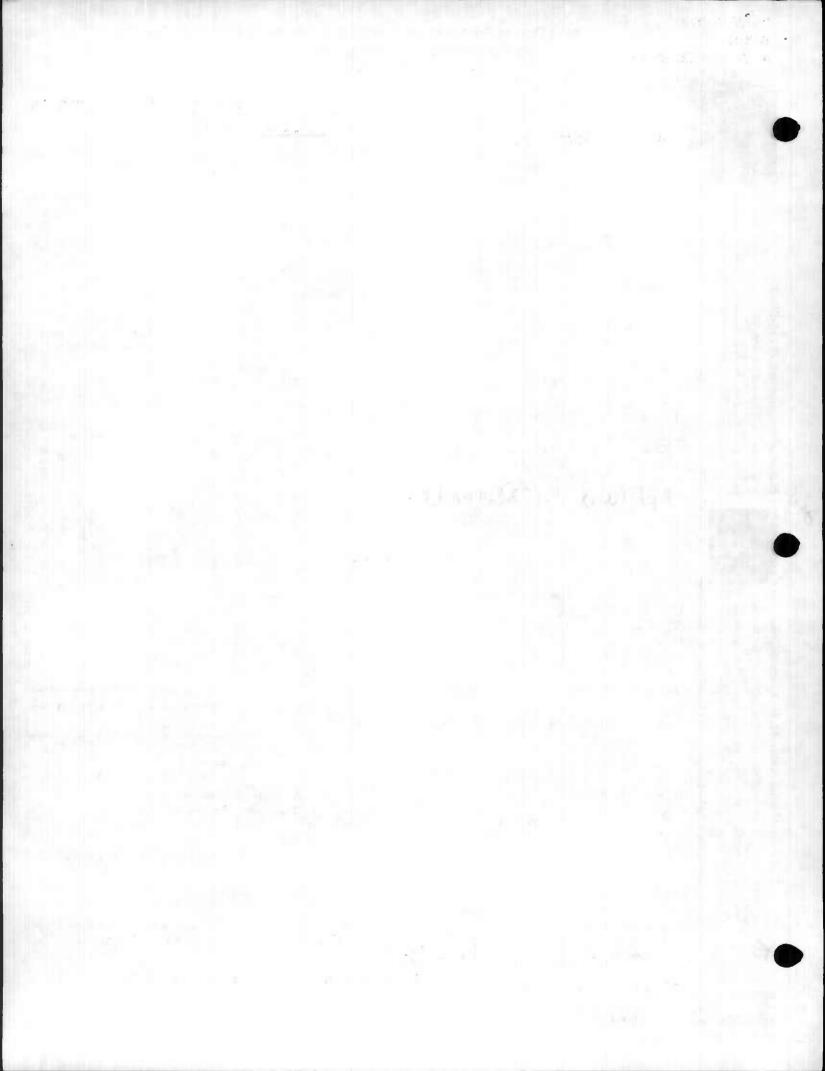
29d. Date signed (Month, Day, Year) MAY 12, 1998

30. Name and address of person who completed cause of death (Item 23ar (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Radentz

Strphen S.
31. Dete filed (Month, Day, Year) MAY 1 9 1998

32, Registrar's Signature Julia Davidson-Randell



		Certificat	te of I	Death	F	leg. No.	0 1/6	108		
e, Last)								a of Deeth		
Marian	В.	Carter			May 1			O PM		
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						-				
6. Sax 7. Ag 1 M 2	e (in yrs. last i	Yrs. If Unday Months	-	Hours Min.	8. Date of Birth (Month, Dey Aug. 31	, 1920	9. Birthplece (Ste Country) England	ate or Foreign		
	10c. City, To	wn or Location					10d. insid	le City Limits		
omerv	Bethe	sda					1 🗆	Yes 2 No		
J			p Coda			10g. Citizen of V	Whet Country?			
treet		20	0817			United	States			
12. Was Decedent	Ever in U,S.	13. Was Dece	dent of H	ispenic Origin? (S	specify Yas or No-			n,		
ried 1 Yes 2 X	No				, , , , , , , , , , , , , , , , , , , ,					
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Last)	EX	por c con	LIUI		me (First, Middle,	Maiden Sumen	ne)			
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(30)	20b Plece	of Disposition (Na	me of		Date					
			·		5_10_00	Reltsvi	lle Mary	vland		
21. Signeture of Funeral Service Licensee Rapp Funeral Services, P. A.										
& Dilap	0	933 Gi	ist A	lvenue, S	Silver Sp	oring, N				
only one cause on each li	I the death. D ne.	o not enter the mod	de of dyin	ig, such es cerdia	c or raspiratory er	rest,	tnterva	Between		
••-										
e. Myocard							Acı	ite		
	Due to (or es									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury										
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c	Due to (or es	e consequence of):	:							
L.	(24-2-100 40)					i			
a .							1			
ons contributing to death b	ut not resulting	in the underlying	causa giv	an in Part i.						
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	y Year)	In i ury M								
alned 266. Place of Ing	ury - At home, c. (Specify)	farm, street, factor	ry, office				ber or Rural Routa	Number,		
ng Physician: To the best	of my knowled	ge, death occurred	at the tir	me, date end plece	e, end due to the ourred et the time	cause(s) and m	anner as stated.	use(s)		
and manner sta	29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, death occurred at the control of the control of the properties of th							and .		
	100.	20		07099		29d. Date signe	ed (Month, Day, Ye	ear)		
	in, give street and number) itreet 6. Sax 1	Marian B. In, give street and number) Street 6. Sax 1	Marian B. Carter In, give street and number) Street 6. Sax 1	Marian B. Carter In give street and number) Street 6. Sax 77 Yrs. 10c. City, Town or Location Bethesda 10f. Zip Coda 20817 12. Was Decedent Ever in U.S. In Jes 2 Wo Hyse, Specify Cubs Int's Education St grade completed) College (1-4or 5+) Export Control Last) es ship (Type, Pnnt) er (Son) 19b. Meiling Address (Street Rapp Funer 933 Gist F r complications thet seused the death. Do not enter the mode of dyir conty one cause on each line. Myocardial Infarction Due to (or es e consequence ot): c. Due to (or es e consequence ot): d. Hospital: Inpatient 2 EF/Outpetient 3 DOA Other of the place of Injury (Month, Dey Year) 28b. Time of Injury M Other place o	Marian B. Carter In, give street and number) Street Sex Table T	Marian B. Carter Marian B. Carter Marian B. Carter May 1 Ab. City, Town, or Location of Death Morth May 1 Street and number) Street Bethesda Sax 77 Yrs. Bethesda 10c. City, Town or Location Months Days Hours Min. Month, Day Aug. 31 10c. City, Town or Location Months Days Hours Min. Month, Day Aug. 31 10c. City, Town or Location Months Days Hours Min. Month, Day Aug. 31 10c. City, Town or Location Months Days Hours Min. Month, Day Aug. 31 10c. City, Town or Location Months Days Hours Min. Month, Day Aug. 31 10c. City, Town or Location Months Days Hours Min. Month, Day Aug. 31 10c. City, Town or Location Months Days Hours Min. Month, Day Aug. 31 10c. City, Town or Location Months Days Hours Min. Months, Days Hours Min. Min. Min. Min. Min. Min. Min. Min.	Marian B. Carter Ab. City, Town, or Location of Death May 18, 1998 May 19, 1998 May 19, 1990 May 19, 1	Marian B. Carter May 18, 1998 A: 3 Temporal report of the country of Death May 18, 1998 Marian B. Carter May 18, 1998 A: 3 Temporal report of Death May 18, 1998 A: 3 Temporal report of Death May 18, 1998 A: 3 Temporal report of Death Marian B. Carter May 18, 1998 A: 3 Temporal report of Death Marian Report of Death Marian Report of Death Marian Report of May 18, 1998 Months Deaders House May 1906 Months Death Sala		

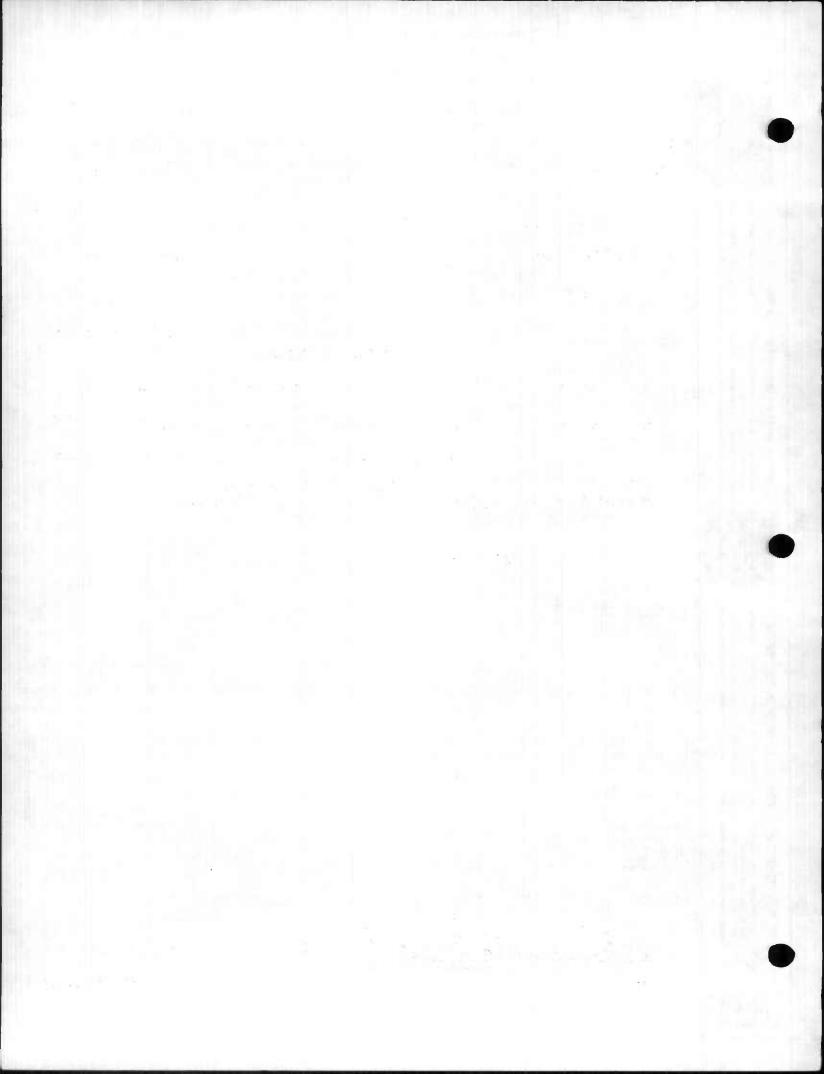
State Registrar

Francis C. Mayle, Jr., M. D.,

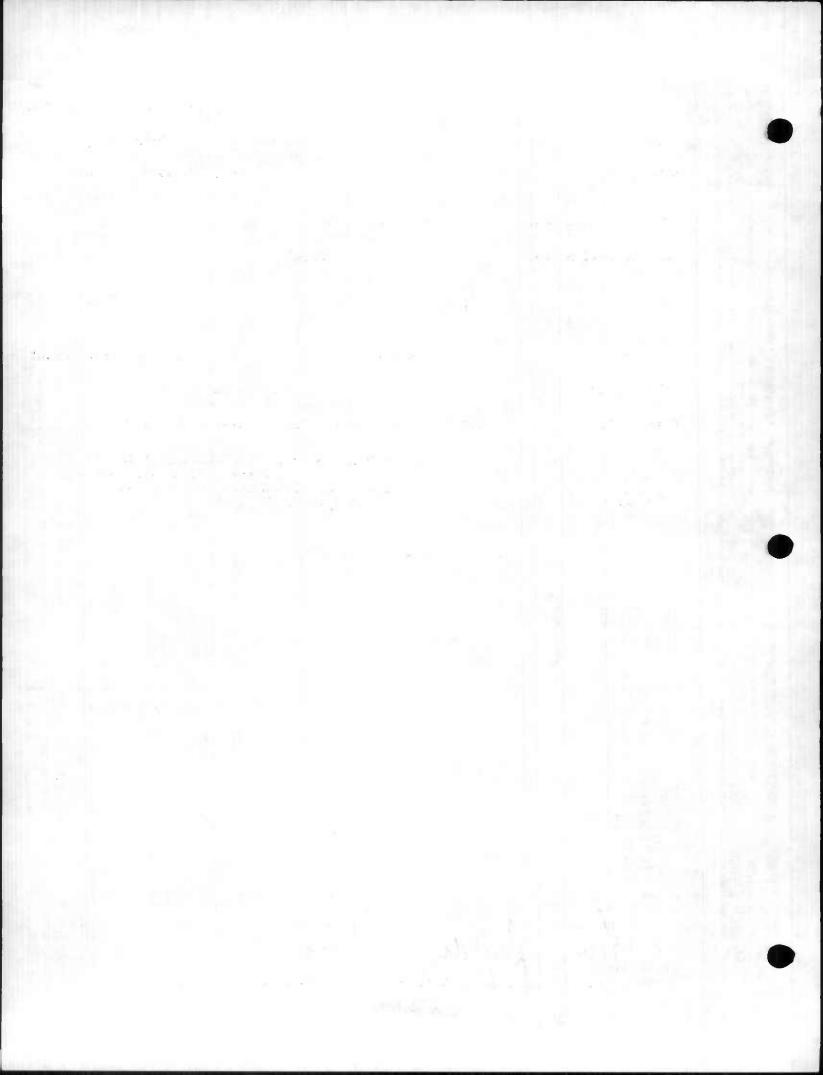
31. Date filed (Month, Day, Year)

32. Registrar's S

WAY 2 0 1998 10215 Fernwood Road, #301, Bethesda, MD 20817-1106



	1 D	ecedent's Name	a (First Middle	(ast)			Cer	unca	e or i	Death	2. Date of De	Reg. No.		3. Time of Dea	
ysician	1.0		. Coole								Month May 1	Day	Year	11:15A	
Medical	4e [ecility Neme (/		_	d number)				b. City, Town, or	Location of Deal	-	ty of Death	11.138	
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eral	5. S	ociel Security N		6. Sex	7. A	ge (In yrs.	last birthday)		r 1 Yeer	If Under 24 Hrs	s. 8 Dete of Bi	rth	0	place (State or Fo	
ctor	57	9-12-39	967	1 € M 2 □] F	78	Yrs.	Months	Days	Hours Min		7, 1919	Mary	land	
	-	al Residenca of													
4 .	. 7.5	State	10b. County			10c. Cit	ty, Town or Loc	cation						10d. tnside City Li	
cto	MI)	Montg	omery			Wheato	n				1 ☐ Yes 25			
l by Funeral Director	10e.	10e. Street and Number 10f. Zip Code										10g. Citizen o	f What Cou	ntry?	
Funeral Director	26	07 Line	dell St							0902			USA		
- Pu	11.1	Marital Status		Armo	Decedent ed Forces	Ever in U	,S. 13. V	Vas Dece Yes, spe	dent of H	ispanic Origin? (: n, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ece - Ameri lack, White,		
by F		□ Never Marri		46 V ~	Yes 2□ s, Give		, = 1	☐ Yes	2 € No	Specify:		Spec	ily: Wh	ite	
D.		50 AAIGOMBG			r or Dates:	1943.		iontie I lei	al Occur	ation		16b. Kind of			
Completed			15. Decedent' ify only highest	grade comple	eted)		16a. Deced (Give I	kind of w	ork done	during most of we	orking	TOD. KING OF	Dusinessin	loustry	
E	E	ementary/Seco	ndary (0-12)	Colle	ege (1-4or	5+)	Condu					Railro	ad Tr	ansporta	
Ö	17.1	ather's Name	(First, Middle, L	ast)			Condu	CCOL		18. Mother's Na	ame (First, Middle			ansporea	
To Be		ho Coo.								Lucil	le Sull	ivan			
Dice. To Be Completed		. Informant's Na		lp (Type, Print	t)		19b. Mailin	g Addres	s (Street		Rural Route Numb		m, State, Zij	p Code)	
	Ca	arl Cool	lev		(s	on)	2607	Lind	e11	Street.	Wheaton	, MD 2	0902		
		Method of Disp			,,,	20b. F	Place of Dispos	sition (Na	me of		Date	20c. Locatio		own, State	
					from Stete	9					5/20/98	Rockyd	110 N	MD.	
	-	1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lip ☐ 22. Name end Address of Facility										Francis J. Collins Fun			
Drice.		21. Signature of Funeral Service Alcohology 22. Name end Address of Facility Francis J. Collins F Home, Inc. 500 University Blvd. Wes													
	224	Part1 Entert	our o	CALCA COMPANIONS	that cause	d the deal	Si Do not ente	lver	Spr	ing, MD	20901 ac or respiratory	arrast	-	Approximata	
dical Examiner	Seq if ar	uentially list co	nditions,	b		ì	or as a conseq							1231	
edical E	Cau	se. Enter Unde se (Diseese or initiated events	injury	C		0.5 1.7									
		iting in death) I	Last			Due to (c	or as a consequ	uence of)	•						
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icia	Part	It. Other signif	Icant condition	s contributino	to death i	but not res	sulting in the ur	nderlying	cause div	en in Part I.	23b. Dic	i tobacco uas	contribute	to the cause of de	
Physician/M		it. Other signi	icant condition	is contributing	y to doutin	DUCTION TO	alling in the al	ruony mg	oadaa gir	on my anti-		Yss 2⊠N		obably 4 Uni	
by P				-							4				
snould be detected for use at leted by Physician/Me												s an autopsy formed?	81	Vere autopsy findi vailable prior to	
Completed														ompletion of caus f death?	
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Be		Wes case refer	red to medical							26. Place of De	eath (Check only	one)			
.0		1 ☐ Yes 2 🔀	No	Hospital:	1 🗆 Inpat	ient 2	ER/Outpatien	t 3 🗆 C	OA Oth	er: 4 Nursing	Home 5 🙀 Res	sidence 6 🗆	Other (Spec	ity)	
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catio		2 Accident	investig	ation				М		Yes 2 □ No					
Certification:		3 ☐ Suicide 4 ☐ Homicide	determi	28e.	Place of Ir building, e	ijury - At h tc. <i>(Speci</i> i	ome, farm, stre	eet, facto	ry, offica		28f. Location City or To	(Street and Nu own, State)	mber or Rui	ral Route Number,	
edicai	29a	Check only	1 Certifying 2 Medical E	xamtner: On	the basis of	of Aamine	owledge, death stion and/or inv	occurre estigatio	tet the tir n, in my c	ne, date and plac pinion, death occ	ce, and due to the curred at the time	e cause(s) and , dete end plac	manner as e, and due	steted. to the cause(s)	
	-	Λ.	the of certifier	1	l manner s	17		25	c. Licens	e number		29d. Dete sig	ned (Month	, Day, Year)	
<u>₹</u>	29b. Signature and the of certifier 29c.														
	Man Dight								03888	Ø		May 1	7, 199	10	
	20 1	Jame and all.		the com	1000	death dies	was /Tune	Print1							
×					Gaude of	30. Name and advess of person who completed cause of death (Hern 33a) (Type, Print) Harry J. Bigham, M.D. 6410 Rockledge Drive, Bethesda, MD 20817									



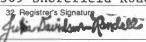
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day Year **Physician** 19, Evelyn W. 1998 7:15AM May /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Montgomery Holy Cross Rehabilitation and Nursing Home Burtonsville If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Days Hours Min. (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociei Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 250 F Jan. 4, 71 516-26-6736 1927 North Dakota Director Usuel Residence of Decedent with the Manyland 10d. fnside City Limits 10a State 10b County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avant, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Silver Spring MD Montgomery Direct 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10709 Tenbrook Drive 20901 USA permit. Pages 1 and 2 should be filed within 72 hours efter death \text{Deportment of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, ir a Medical Energy men. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Race - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 1 Ves 2 No Specify: Specify: White þ 3 DtWidowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) NIH Secretary 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Aden Wescom Dola Gwynn 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informent's Neme/Reletionship (Type, Print) 10709 Tenbrook Drive, Silver Spring, MD James W. Cope, Jr. (son) 20901 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State Gate of Heaven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 5/23/98 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Punerei Service Licania 500 University Blvd. West Home, Inc. amsei Loper Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each light Approximete Interval Between Onsef and Deeth Physician /Medical immediate Ceuse (Finel Renal Failure disease or condition resulting in deeth) 1 week Examiner Due to (or es e consequenca of): Examiner Volume Depletion 1 week ettending physician end for use es the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lesf Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Metastatic Breast Cancer years Physician/Medical Due to (or es e consequence of): 80 23b. Did tobecco use contribute to the cause of death? ed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given In Part I. signed by t 1 | Yee 2 | No 3 ☐ Probably 4 ☑ Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peen page 2 s 1 Yes 21€ No 1 Yes 2 No certificate or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this After this funeral d 28c. Injury at Work? 27. Manner of Deeth 28e. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending in 24 hours energible Europe. After the Funeral Director: After the Funeral filled in by the fur 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner as stated.

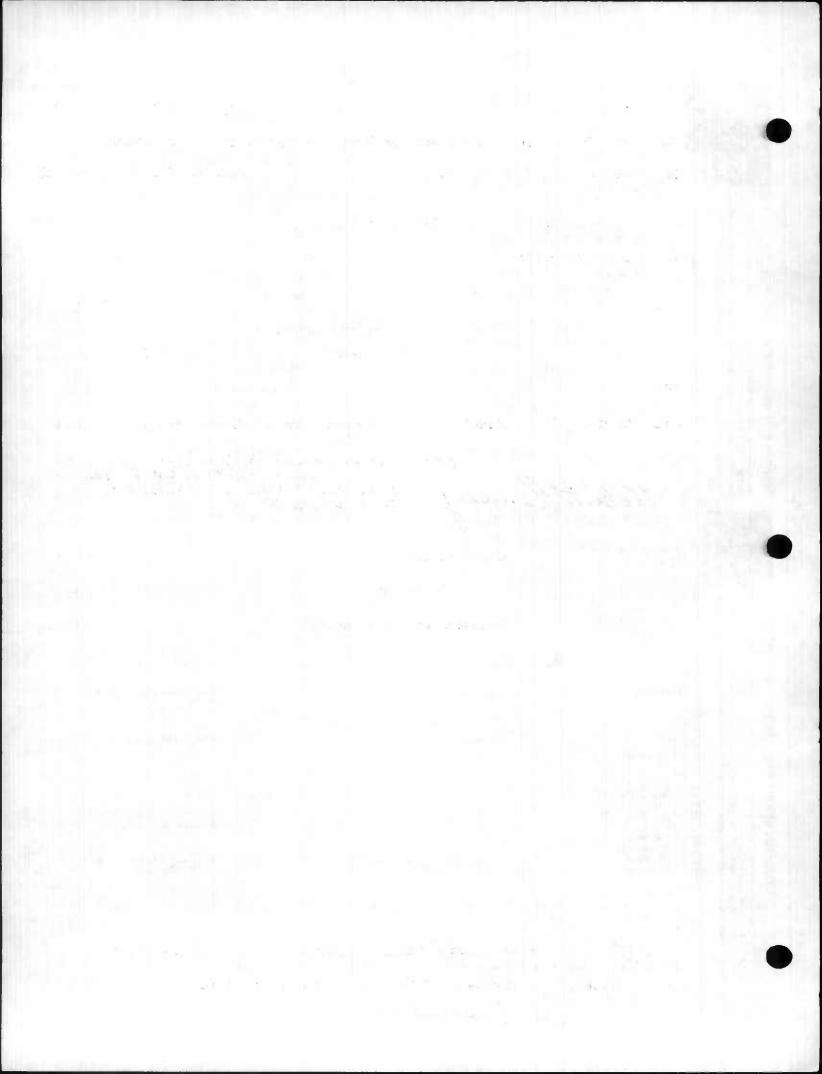
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier edicai (Check only one) within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D41931 May 20, 1998 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 2309 Shorefield Road, Wheaton, MD R. Shumacher, M.D. 20902

State

Registrar

31. Dete filed (Month, Dey, Year) MAY 2 1 1998

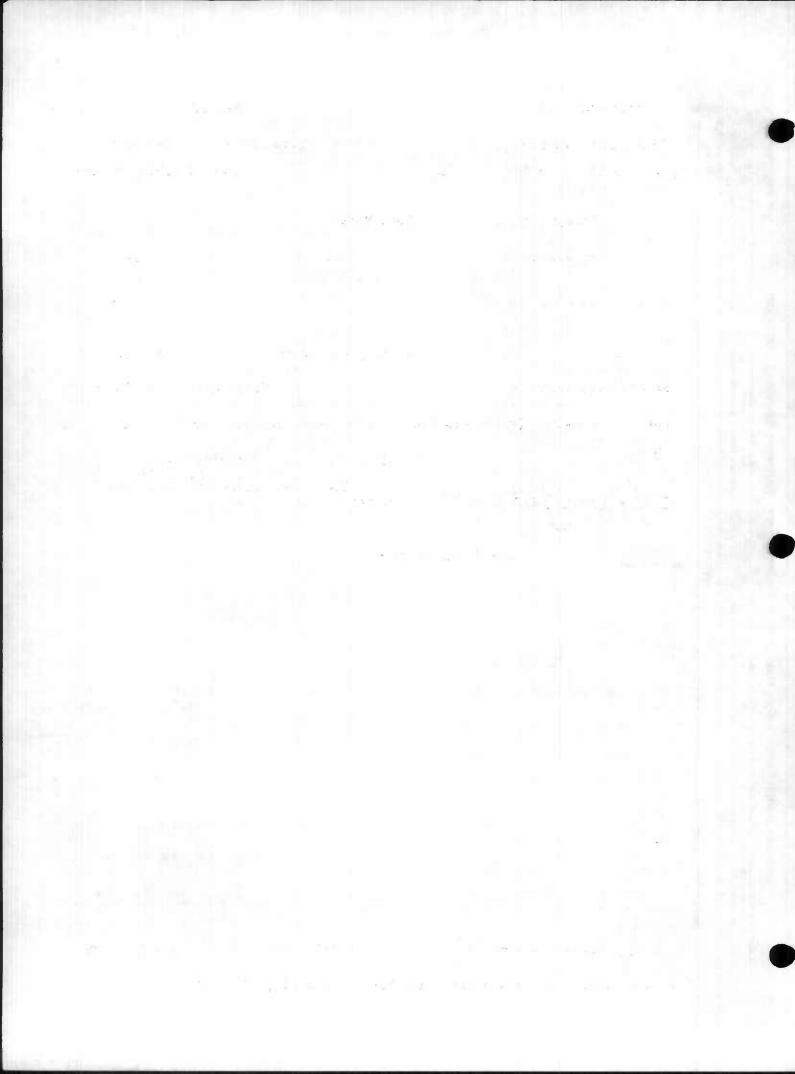




State of Maryland / Department of Health and Mental Hygiene 0 1701

				Certificate	of Death		Reg. No.	111	9 1			
	1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	eath Day	Year	3. Time of Death			
sician edical	Charles Crism	ond				May 17			4:00AM			
niner	4a Facility Name (If not institution,	give street end number)			4b. City, Town, or	Location of Deat	h 4c. County					
1101	8101 Flower Av	enue			Takoma	Park	Mont	gomery				
1		. Sex 7. Age	e (In yrs. last birt	hday) If Under 1 Y	ear If Under 24 Hrs		rth Voor	9. Birthpia	ce (Stete or Foreign			
al or	577-01-6888	1⊠ M 2□ F	85	rs. Months D	ays Hours Min	8. Date of Bir (Month, De April	3, 1913	Virg:	inia			
-	Usual Residence of Decedent											
	10a. State 10b. County		10c. City, Town	or Location		10d. Inside City						
Director	MD Montgo	omery	Tak	coma Park					1 ☐ Yes 2 ☑ No			
ĕ	10e. Street and Number			10f. Zip Co	de		10g. Citizen of	What Country	y?			
	8101 Flower Ave	nue		209	112		US	2 A				
101	11. Marital Status	12. Wes Decedent B	Ever in U.S.			Specify Yes or No		e - American	n Indien,			
Funeral	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 □ N	lo	If Yes, specify	t of Hispanic Origin? (5 Cuban, Mexican, Puer	rto Rican, etc.)	Blad	ck, White, etc	c.			
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:		1 □ Yes 2 🗓	No Specify:		Specif	Whit	te			
8	15. Decedent's	111111111111111111111111111111111111111	16a	Decedent's Usuai O	ccupation		16b. Kind of B	usiness/Indu	strv			
jet	(Specify only highest (grade completed)		(Give kind of work d	ione during most of wo							
Completed	Elementery/Secondary (0-12)	Cotlege (1-4or 5	+)	inting Co			Self-E	implow	od			
5	17. Father's Neme (First, Middle, La	et)	10	illicing co		me (First, Middle			zu			
Be												
2	Nelson Page Cri					lara Est						
	19a. Informent's Name/Relationship				treet end Number or A				000)			
	Mary N. Crismor	nd (sister-			Carson Aver				0745			
	20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3	□ Removal from State	20b. Piaca of cemeters	Disposition (Neme of y, cremetory or other	r plece)	Date	20c. Location	City or Town	n, Stata			
	4 Donation 5 Other (Spe		Fort L	incoln Ce	emetery	ry 5/20/98 Brentwood, MD						
	21. Signature of Funeral Service Lic	ansee			Collins Funeral							
	Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 231 Part Entry the disease or conhibitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one cause on each line.											
	23a. Part . Enthy the disease or co	hplications thet caused	the death. Do n	ot enter the mode of	f dving, such as cardia		arrest.	. A	Approximate			
	shock, or heert feilure. List on	y one cause on each lin	10.		,			ir	nterval Between Onset end Deeth			
n al	immediate Cause (Finat							1				
r	disease or condition resulting in death)	a. Carcin	oma of (Colon								
200	Todaking in doubly		Due to (or es a c	consequence of):				1				
edical Examiner												
Carr	Sequentially list conditions, Due to (or as a consequenca of):											
ω Π	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.											
lica	thet initiated events resulting in deeth) Last	C.	Due to (or as a c	onsequence of):								
2												
		d						1				
Physiclan/	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying caus	se given in Part I.	23b. Did	tobacco usa co	ntribute to t	he cause of death?			
hy							Yee 2□ No		ibly 4⊠ Unknown			
y P			_						28			
Completed by							s an eutopsy	24b. Were	e autopsy findings			
ete							ormed?	com	labla prior to pletion of cause			
du									eath?			
S						1 🗆	Yes 2 No	10	Yes 2⊠ No			
Be	25. Wes case referred to medicat examiner?				T -	eath (Check only	one)					
0	1 No 2 No	Hospital:	nt 2 ER/Out	tpatient 3 DOA	Other: 4 Nursing	Home 5 ₩ Res	idenca 6 □Oth	ner (Specify)				
:U	27. Manner of Death	28a. Dete of Injur (Month, Dey	y 28b. T	ime of 28c.	Injury at Work?	28d. Describe	how injury occur	red				
Certification:	1 Naturei 5 Pending 2 Accident investigat		"	M	1 ☐ Yes 2 ☐ No							
HIC	3 Suicide 6 Could not determine	28e. Piece of Inju- building, etc	ry - At home, fer	rm, street, factory, of	ffice	28f. Location	(Street end Numi	ber or Rural F	Route Number,			
en	- CHOMICON		City of To	, 5(8(8)								
<u>a</u>	29a. Certifier 1□ Cartifying I	Physician: To the best o	of my knowledge.	, deeth occurred et ti	he time, dete end piec	e, and due to the	cause(s) and m	anner as stat	ted.			
edical		aminer: On the basis of and manner sta	examination and									
Me	29b. Signature and title of certifier	2.12.11.01.01.01.01		29c. Li	icense number		29d. Dete signe	d (Month. De	ey, Year)			
	A	- W	. 04									
			OX .	D0:	15236 DME		May 1	7, 199	8			
	30. Name and eddress of person wh	o completed cause of de	eath (Item 23a) (Type, Print)								
	Carl Margolis,	MD 11125 R	ockville	e Pike, Ro	ockville,	MD 2085	2					
e	31. Date filed (Month, Dey, Year)											
ar	MAY 2 0 19	198 Julian	r's Signature.	masse								
w cme		0										

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** CLARA PRETTYMAN COLEMAN May 14 3:05PM 1998 /Medicai 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Birthplaca (Steta or Foreign Country) **Funerai** Days 1□M 2MF Months Hours Min. 97 214-28-3634 Yrs. Nov. 23, 1900 Preston, MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Locetion 10d. Inside City Limits 28a-1 show tam 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar mass be notified at 1 ☐ Yea \$ No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 27820 St. Michaels Road 2 1 6 0 1

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) U.S.A. 12. Wes Decadent Ever in U,S. Armad Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Datas: 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2XXNo Specify: Completed by Specify: White 3 Divorcad 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grede completed) al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Executive Excavating Contractor 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H I Itam 27 Is marked oth Be Wesley William Prettyman Emma Sigman 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) W. Robert Coleman/Son 27815 St. Michaels Road, Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Peges 1 permit. Peges Department of Important: If It any injury or o 12 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spring Hill Cemetery/May 18, 1998 Easton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. CFSP 200 S. Harrison Street, Easton, Maryland 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Finel disaasa or condition resulting in death) **Examiner** multiped atrial tachyearden Physician/Medicai Examiner the bunial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of) physician Due to (or as a consequence of): 98 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? mote Fractice R hip, recent 1 Yss 2 No 3 Probably 4 Unknown be more of Deser þ 8 24b. Were autopsy findings avellable prior to 24a. Was an autopsy performed? Completed completion of cause page 2 a No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 DInpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending n 24 hours efter death.

Puneral Director: Aft bleeky filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 15 certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Madicel Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) and menner stated. 29b. Signeture end title of certifle 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) William Wood, Jr., MD, 506 Idlewild Avenue, Easton, MD 32. Registrary Signature

DHMH 16 Rev 6/95

State Registrar

death with the Maryland

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Box 68760,

Records, P.O.

Division of Vital

Attending

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The law requires that the death certificete be

Coleman

ILES TYAN

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath 3 Time of Death **Physician** May 17, CAMPBELL Clemmie 7:00 am Mary /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Bridge Frederick County 12813 Bunker Hill Road 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. 9. Birthplaca (Stata or Foreign Country) Pennsylvania 7. Aga (In vrs. last birthday) **Funeral** Days 177-16-6386 Months Yrs. Director 81 1916 Usual Rasidanca of Dacedant with the Maryland 10a Stata 10b. County 10c. Cltv. Town or Location 28a-f show 10d. Insida City Limits the Medical Examiner must be notified at Director Maryland Frederick Union Bridge 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ò 12813 Bunker Hill Road 21791 U.S.A. **Нета** 23a death v Funerai 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2% No tf Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If frem 27 is marked other than "natural, or iten any injury or other traumatic event, the Mandal Pages. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2X No Specify: à 3 Widowad 4 Divorcad Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Eiamantary/Secondary (0-12) Coilaga (1-4or 5+) 11 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be DELBARRE STEVENSON Evelvn Leon 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Aural Routa Number, City or Town, Stata, Zip Coda)
12813 Bunker Hill Road, Union Bridge, MD 21791 Shaun N. Campbell/Son 20b. Placa of Disposition (Nama of camatary, cramatory or other placa)
Smithsburg Crematory 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from State May 18,1998 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Lie 22. Nama and Address of Facility Keeney & Basford Funeral Home M00706 106 East Church St, Frederick, Maryland 21701 23a. Part 1. Enter the r. sass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final END STAGE EMPHYSEMA YRS disaasa or condition rasulting in daath) Examiner Dua to (or as a consequança of) Examiner sician and bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, taading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that Initiated avants rasuiting in daath) Last Dua to (or as a consaquanca of): P.O. Box 68760, physician s the bunal Physician/Medical Dua to (or as a consequence of): as ata has been signed by the a paga 2 should be detached Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records. þ Be Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No certificata 1 ☐ Yas 2 ☐ No director. 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa Rasidanca 6 ☐ Othar (Specify) Medicai Certification: To 1 Yas No After this filled in by the funeral 27. Mannar of Death Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Natural To the Hospital or Attendition within 24 hours after death. To the Funeral Director: A 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 \ Homicida 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) w 30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print) AVIZ FREDFILL MD 21702 WARAND FICAR MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State eva Davidson Rachell Registrar WAY 1

ar-sia marro

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Deeth 3. Time of Death Month Dev Year :45 AM **Physician** 1998 Clyde Collins May 14, В. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Frederick Frederick If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months 90 Director 577-60-5538 June 1, 1907 Mississippi Usual Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mentel Hygiene.
Int: If them 27 is marked other than "natural", or frema 23s or 28s-f show kry or other traumatic event, the Medical Examiner must be notified as 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Frederick Maryland Frederick 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 N. Pendleton Court 21702 United States Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced white Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant US Naval Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Lee Brown Clyde Steele 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) permit. Pagas 1 and Department of Health Important: If them 27 any injury or other tr phcs. Pairicia Harry / daughter 8604 Fire Rock Road, Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Memorial Gardens 5/18/98 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, 21. Symmon of Funeral Service Licensee Frederick, MD 21702 23a. Part1. Enter the disease, or complications that ceused the deeth shock, or heart failure. List only one cause on each line. at enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset and Death **Physician** ovasiular Disease /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequença of) Examine physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): attending pl signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ 24b. Were autopsy findings avallable prior to should 24a. Was en eutopsy Completed completion of cause of death? nis certificate has b 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) After Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manufactured stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

completed cause of deeth (Item 239) (Type, Print)

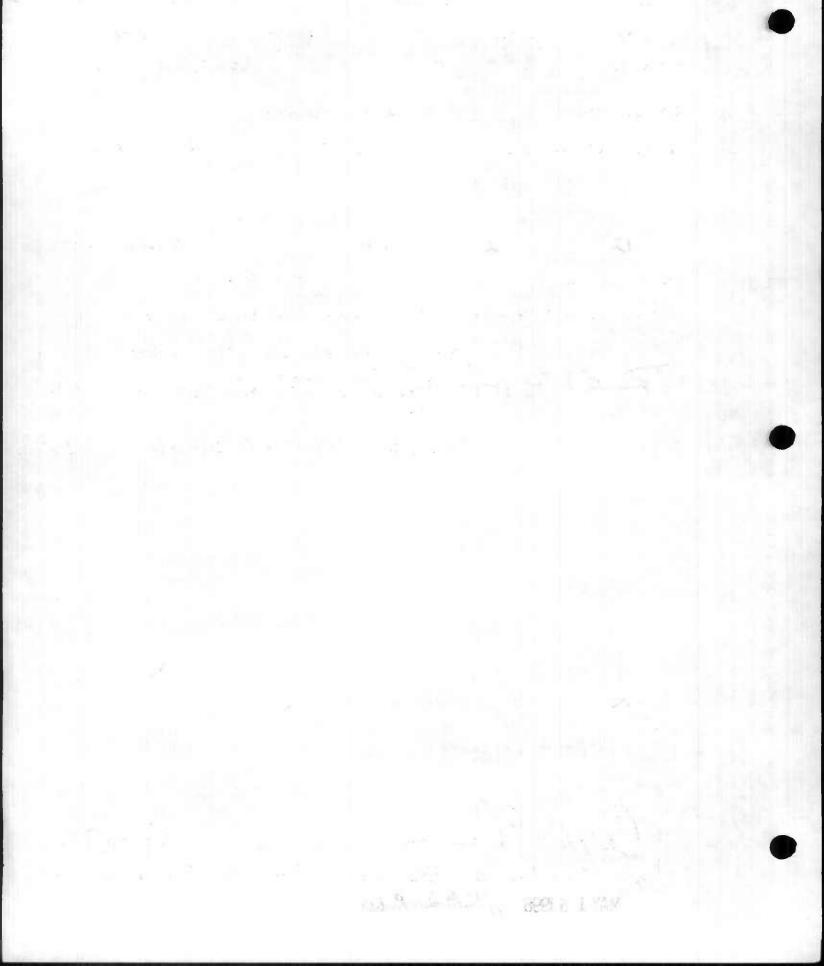
32. Registrar's Signature

State Registrar 30. Name end address of person who

31. Date filed (Month, Day, Year)

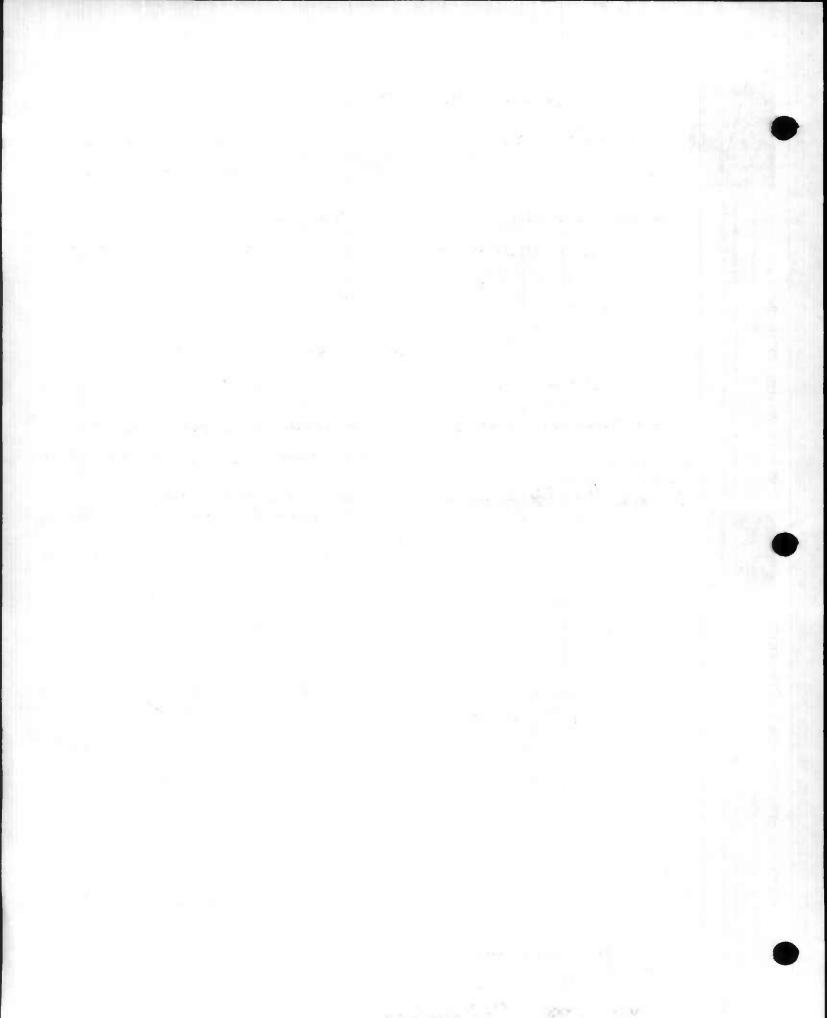
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MAY 1 5 1998



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			State	OI Maryland		ertificate of			g. No. 98	17	1015					
	Physici /Medie		Decedent's Name (First, Middle, Last) GLADYS E.	Lizabeth	COOF	PER		2. Date of Death Month MAY	Day 19	Year	3. Time of Death 3:49 PM					
	Examir		4a. Facility Name (If not institution, give street and				4b. City, Town, or Lo		4c. County							
			117 East Fifth Str				Frede			Frede						
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 1 1 1 M 2 1 1 F	7. Age (In yrs. Ia 87	est birthda Yrs.	y) if Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 5,	Year) 1911		ce (State or Foreign					
	lend Market		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or	Location				10d	. inside City Limits					
	Mary	tor	Maryland Frederick			Free	derick				1√ Yes 2 No					
	death with the Marylend	ai Direc	10e. Street and Number 117 East Fift	h Street		10f. Zip Code	217		g. Citizen of W		S.A.					
21215-0020	or the	Completed by Funeral Director	1 Never Married 2 Married 1 Yes,	ecedent Ever in U,S Forces? s 24 No Give r Dates:	5. 13	B. Was Decedent of H If Yes, specify Cube		cify Yes or No- Rican, etc.)		e - American k, White, etc						
5-0	72 ho	eted	15. Decedent's Education (Specify only highast grada complate	na 1	6b. Kind of Bu	siness/indus	stry									
121	within ene. than "	mple		(1-4or 5+)	lifa	re kind of work dona . DO NOT use retired estic worl	d)									
2	her ti	Co	17. Father's Name (First, Middla, Last)		DOM	estic work		/First Middle M	Domest							
and	od be	Be c	William P. Ja	ckson				Name (First, Middla, Maidan Sumame) nie Miner								
Maryland	should Me mark	To	19e. Informent's Name/Relationship (Type, Print)		19b. Ma	iling Address (Street			City or Town,	Stata, Zip Co	oda)					
Baltimore, Ma	permit. Pages 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avent, the Medice.	Minyon Cooper Lewis/Daughter 1418 Taney Avenue K203, Frederick, MD 20a. Method of Disposition 20a. Method of Disposition (Nama of cemetary, cramatory or other place) 20b. Place of Disposition (Nama of cemetary, cramatory or other place)														
I	oft. Partme		Wayman AME Church Cemetery May 16, 1998 Mt. Pleasant,													
Ba	Depariment important		Wayman AME Church Cemetery May 16, 1998 Mt. Pleasant Maryland													
1	Physician /Medical Examiner	ı.	23a. Part1. Enter the disease, or complications the shock, or heart fellure. List only one cause o Immediate Cause (Final disease or condition resulting in death)	Carcha	ic_	amest	ng, sash as obtobe s	ичевриваюту акто	ecuel 10		inutes					
x 68760,	certificete be executed iding physician and ise es the burial-transit	√Medicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Last			equence of):				.						
Box	saath certif attending d for use e	Iclar	Part II. Other significant conditions contributing to	dooth but not rock	Itina In the	Tindorhilas causa sh	on in Part I	23h Did tol	20000 1100 000	stribute to ti	he cause of death?					
P.O.	requiras that the death certi een signed by the attending hould be detached for use t	y Physician/M	Athma	death but not resu	ating in the	underlying cause giv	ven in Per I.	1 TY	_/		bly 4 Unknown					
Records,		Completed by						24e. Wes er perform		availe	e autopsy findings able prior to pletion of cause seth?					
æ	m E 9	mo						1 ☐ Ye	s 20 No	101	Yes 2□ No					
ita	iclan: The certificata rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	V.							
> 1	2 00	Lo	1 Yes 2 No Hospital: 1	□ Inpatient 2 □ I	ER/Outpat	ient 3LI DUA		me 5 Reside	nce 6 Oth	er (Specify)						
ū	ng Pl		27. Manner of Death 1 SNetural 5 □ Pending (M	te of Injury onth, Day Year)	28b. Time Injury	/ Wo		28d. Describe ho	w injury occuri	red						
Division of Vital	To the Hospital or Attanding Phy within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ace of Injury - At ho ilding, etc. (Spacify	me, farm,	M 1 □	Yes 2 No	28f. Location (Str City or Town		er or Rural F	Routa Number,					
	papital of hours elumeral D	cal Ce	29a. Certifier 1 Certifying Physician: To													
	the Hallin 24 the Fu	Medical	one) and m	anner stated.	ion end/or											
	To To To	2	29b. Signeture end title of tertilier	ND		29c. Licens	947535	29	5/13	Month, De	iy, Year)					
			30. Namer and address of person who completed co	64 Op	ossui	+	Pike 7	redenc	K M	10	21702					
	Sta Registi		31. Date filed (Month, Day, Year) 32 MAY 1 4 1998	Registrar's Signal	rure Red	ek										

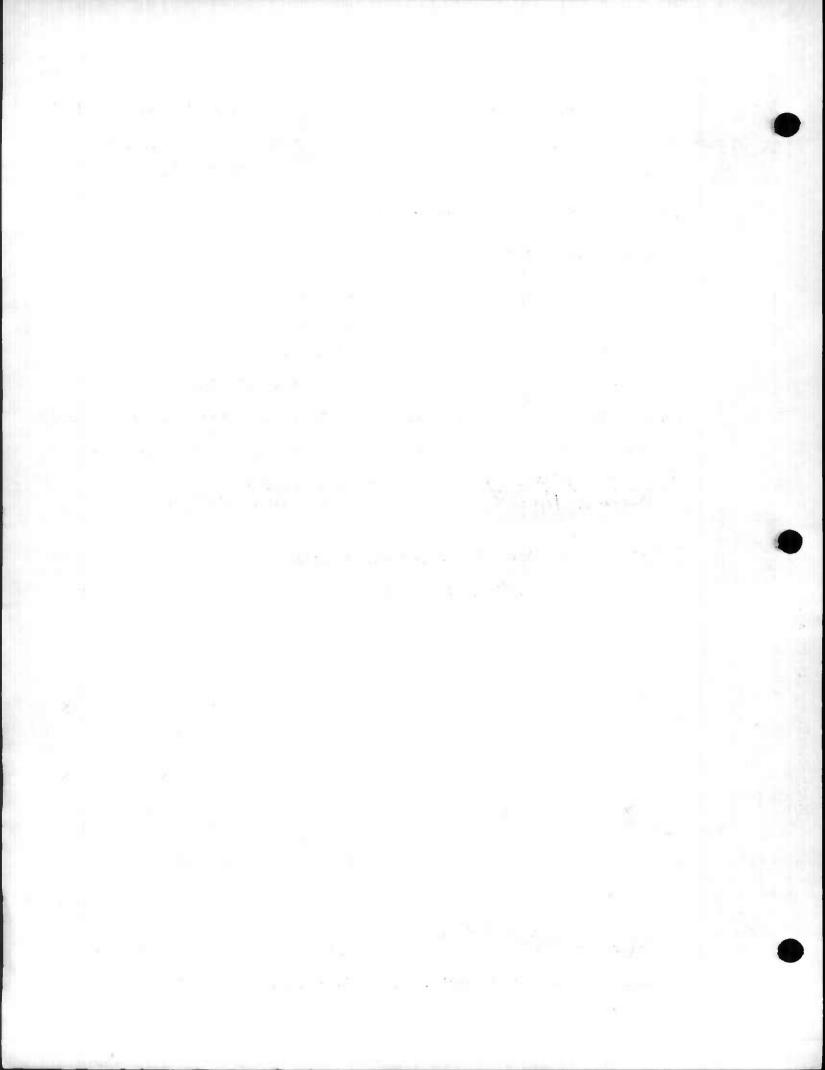


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				State Of Ma	ai yiai ii				Death	ivientai riy	Reg. No.	38	17018)		
	Physici	an	Decedent's Name (First, Middle, Le	,						2. Date of De	eath Day	Year	3. Time of Deal	th		
	/Media	cai	WILLIAM JOSEPH				_			May	22, 199	98	1:45	pm		
	Examir	ier	4a. Facility Name (If not institution, give	,					4b. City, Town, or			nty of Death				
H	Funeral		Memorial Hospita 5. Social Security Number 6.5		e (In yrs. le	ast birthdey)		r 1 Yeer	Cumberla If Under 24 Hrs		A]	llegan	y place (Stete or For	reian		
	Director		214-01-3711 Usuel Residence of Decedent	Sex 7. Age	95	Yrs.	Months	Days	Hours Min.	8. Date of Bi (Month, Di FEB 28	1903	MARY	LAND			
	fand w		10a. State 10b. County		10c. City	, Town or Loc	ation					- 1.	10d. Inside City Lin	nits		
	Mary B-f sh	tor	MARYLAND ALLEGA	NY	CI	MBERLA	AND						Yes 2	No		
	or 28	Sire	10e. Street and Number				10f. Zi	p Code			10g. Citizen o	ntry?				
	23e	la	432 NORTH CENTRE STREET 21502								U.					
21215-0020	be filed within 72 hours efter death with the Maryland stel thyglene. Identify than "natural", or items 23e or 28e-f show event, the Medical Examination notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent I Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:			/as Dece Yes, spe ☐ Yes		lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		lace - Americ Black, White, city:WHIT	etc.			
5-0	72 ho netur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working)								16b. Kind of	Business/In	dustry			
121	within ane. than	idmo	Elementery/Secondary (0-12)	College (1-4or 5	+)	life. D	O NOT L	ise retired	1)		SALES	M A M				
9	filed within Hygiene. other than sent, the Mention Men															
Maryland	12 should be find and Mentel Is marked of reumatic even	To Be	JOSEPH CESNICK							CATHERIN		JHAUS				
lan	and Notes	Elementery/Secondary (0-12) 8 College (1-4or 5+) MONTGOMERY WARD (1-10) 17. Fether's Name (First, Middle, Last) JOSEPH CESNICK 19a. Informent's Name/Relationship (Type, Print) EDITH E. CESNICK WIFE 432 NORTH CENTRE 20a. Method of Disposition 20b. Place of Disposition (Name of												_		
	Health Health em 27		EDITH E. CESNICK	WI	_	432 NO			TRE STRE				ND 21502			
Baltimore,	8 0 = P				XY 26 199	98 CUMBERLAND MARYLAND										
Ball	permit. Per Depertmen important: any injury once.		21. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.													
	-		23a. Part1. Enter the diseese, or com shock, or heart failure. List only	23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
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	Examiner	_	resulting in death)			as a consequ			T2FV2F				LU IEARS			
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68760,	ate be nysicie he bu	edicai	Cause (Disease or Injury that initiated events pue to (or as e consequence of): Due to (or as e consequence of):													
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Box	eeth cer ettendin for use	lan		d.												
o.	that the de ed by the e deteched	Physician/N	Pert ii. Other significant conditions of	ontributing to death bu	it not resul	lting In the un	derlying	cause giv	en in Part I.	23b. Did	tobacco use	contribute to	o the cause of de	ath?		
0	signed by d be detec	y Ph					_			10	Yes 2□ No	o 3□ Pro	bably 4 Unkr	nown		
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Re	S S CA	dmc									v. alleria		death?			
Vital		Be C	25. Was case referred to medical						26. Place of Dec	1 □			☐ Yes 2 KNo			
of V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospitel:	nt 2 E	R/Outpatient	3□ D	OA Oth	O.C.	lome 5 ☐ Resi		Other (Specif	ý)			
ion o	Attanding Ph r deeth. ector: After th by the funeral		27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Dete of injur (Month, Dey	Year)	28b. Time of Injury	М	28c. injur Wor 1 □	yat k? Yes 2 □ No	28d. Describe	how injury occ	urred				
Division	s efter de il Directo ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)							281. Location (City or To	Street end Nu wn, Stete)	mber or Rura	al Route Number,			
	To the Hospital or Attanding I within 24 hours effer deeth. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifying Ph (Check only one) Certifying Ph 2 Medical Exam	ne, date and plece pinion, death occu	, and due to the irred et the time,	cause(s) and date end plac	manner as s e, and due to	tated. the cause(s)								
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	nn	J	ND	29	c. Licens	e number		29d. Date sig	ned (Month,	Dey, Year)			
	5			700	- 1	1 1		D 23:	371		May	23 1	998			
	MISS	30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)							4			F				
		40	Dr. Zaman, Johnso					Cui	mberland	, MD 21	.502					
	Sta Registr	_	31. Date filed (Month, Day, Yeer) 32. Figure 32. Signature													

214-01-3711

WILLIAM CESNICK



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First Middle Last) 2. Data of Death 20,1998 Month **Physician** Sadie Victoria D'Armi 1:35 AM May /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 203 Maple Avenue Federalsburg Caroline If Undar 1 Yaar If Under 24 Hrs. 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Deys 1□ M 2 F 86 Yrs. 213-22-8362 Director 05/29/11 Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-1 show r is marked other than "naturel", or items 23a or 28a-f shoo traumstic event, the Maoical Examinar must be notified at MD Caroline Federalsburg 1 □ Yas 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 203 Maple Avenue 21632 United States 234 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturelt, or items 23a any injury or other traumatic event, the Magnes Exercises 2008s. Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 14. Race - Amaricen Indian, Bleck, White, etc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Ricen, atc.) 11. Maritel Stetus 1 □ Yas 2 ☒ No If Yas, Giva Yeer or Datas: 1 Naver Merriad 2 Marriad Baltimore, Maryland 21215-0020 White 1 Yas 2 No Specify: by 3 XWidowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Retail Shoe Shop Business Owner 17. Fethar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Meidan Sumema) Be Lillian Seabrease Herbert Jackson 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Barbara Williams/Daughter 6950 Reliance Rd., Federalsburg, MD 21632 20b. Place of Disposition (Nama of cematery, cremetory or othar plece) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stete 1 Burlal 2 □ Cramation 3 □ Ramoval from State Hill Crest Cemetery 5/22 Federalsburg, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Framptom-Hawkins-Eskow Funeral Ho
PO Box 43, Federalsburg, MD 21632 21. Signetura of Funaral Sarvice Licenses row 23a. Part1. Entar the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Batween Onset end Deeth **Physician** Immediata Cause (Finel disease or condition rasulting In death) /Medical Examiner Physician/Medical Examiner physician end the buriel-transit Sequantially list conditions, if any, leeding to Immadiata ceuse. Enter Undarfying Ceusa (Diseasa or Injury that initieted events rasulting in death) Last Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 10.0 1 Yss 2 0 No 3 Probably 4 Unknown signed I þ 24b. Ware eutopsy findings evalleble prior to compiation of cause of deeth? Completed 24a. Was an autopsy performed? page 2 s 1 🗆 Yes al or Attending Physician: To sefter death.

I Director: After this cerificated in by the funeral director, pages. 25. Wes cesa referred to medical axaminer? Be 26. Place of Death (Check only ona), Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury et Work? 1) Natural 2 Accidant 5 Panding investigation 1 Xer 8 Could not be datarmined 3 Sulcida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in edical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the causa(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 198 30. Nama and address of person who completed couse of death (Item 23a) (Type, Print) Lois Narr,

2 Aurora Street, Cambridge, MD 21613

State

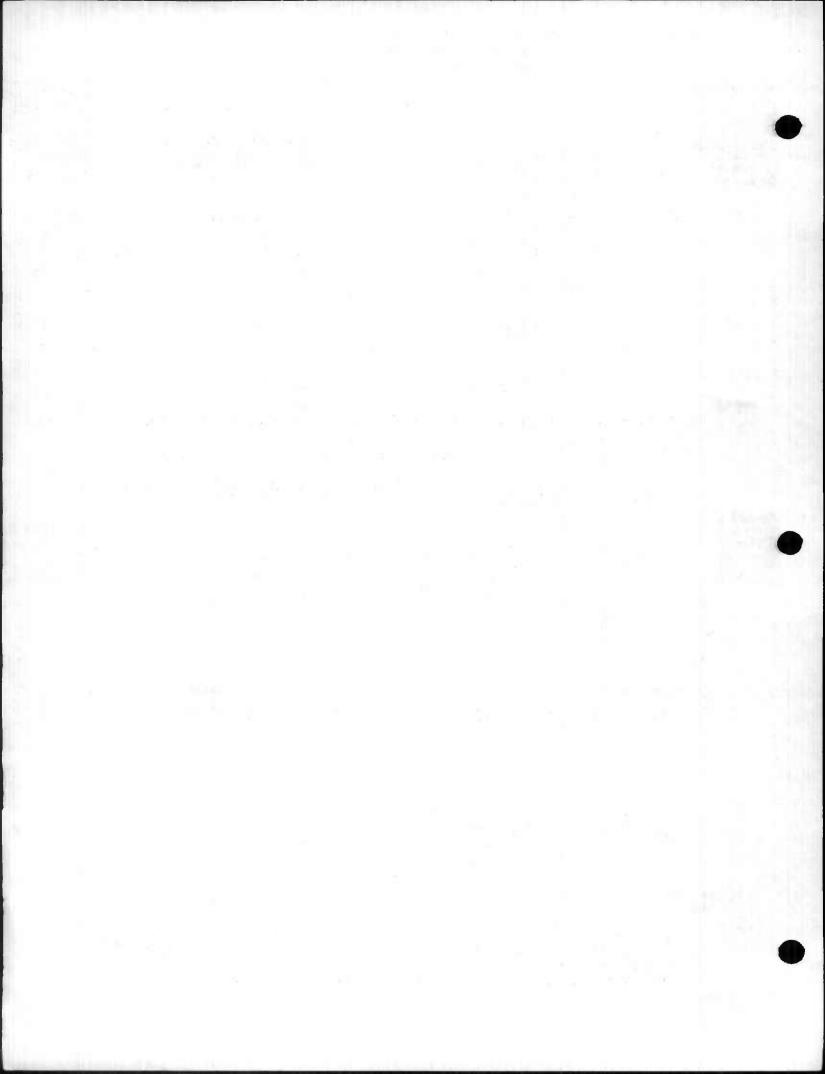
Registrar

D.O.,

'98

32. Registrar's Signatura

Aichia Davidson-Randale



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** 20, 1998 3:44 P.M. MAY JOHN DELL'ERBA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner ROCKVILLE If Under 24 Ars. Hours Min. Min. SEPT. 28, SHADY GROVE ADVENTIST HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Under 1 Year MONTGOMERY Birthplece (State or Foreign Country) Months Days XXM 2□ F 1915 WASHINGTON, D.C 82 578-09-2125 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MXYes 2 No Director MARYLAND PRINCE GEORGES HYATTSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1305 RAY ROAD 20782 UNITED STATES Funeral Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Meritel Stetus XXYes 2 ☐ No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married 1 ☐ Yes ŽÍXNo Specify: by XXWidowed 4 □ Divorced WHITE WWII Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) MASONRY 12 STONE MASON 0 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) ANTOINETTA LEOGRANDE LEONARDO DELL'ERBA Commit. Pages 1 and 2 shc. Department of Health and M. Important if hem 27 is many injury or other. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JUDITH L. DELL'ERBA 1305 RAY ROAD, HYATTSVILLE, MARYLAND 20782 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition XX Buriel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 5-23-98 SILVER SPRING, MARYLAND of Funeral Assiste Licens 22. Name end Address of Fecility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth e. SEPS Due to (or es e consequence of): mediate Cause (Final disease or condition resulting in death) PNEUMONIA Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Drabetes Mellitus 1 Yes 2 No 3 Probably Winknown Àq PERIPHENAL VOSCULAR DISEASE 24b. Were eutopsy findings evelleble prior to completion of cause of death? Completed 24e. Wes en eutopsy 1 ☐ Yes > No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25€No 70 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month, Dey, Year)

MAY 20, 1998

pur physician 4 8 Bulpuegn 880 ed by the Division of Vital Records, certificate funeral director this After Attending or Attending efter death. Director: After Hospital 24 hours 6

signed by the

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

the Merylend

with

filed within 72 hours efter death

3 2 should be filed within 7 h end Mental Hygiene.

Physician

/Medical

To the To the Comple 3+1

> State Registrar

edical

29a. Certifier (Check only one)

31. Dete filed (Month, Day, Year)

29b. Signatore and title of certif

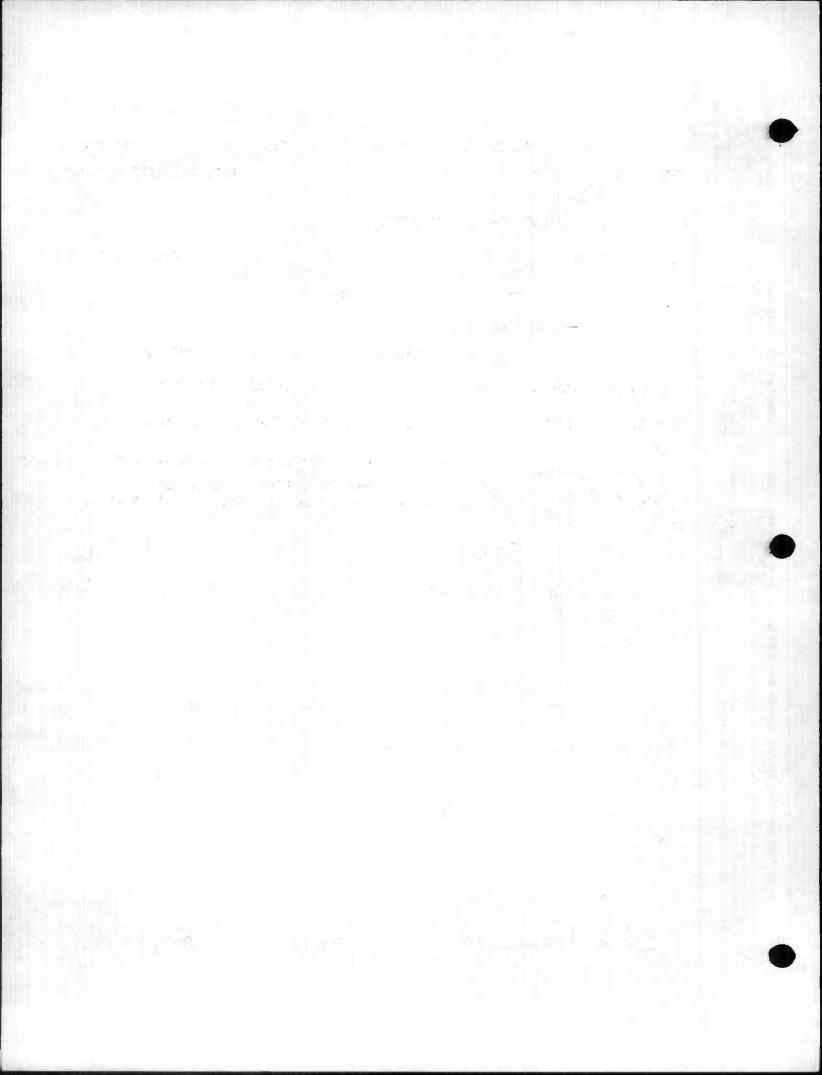
MAY 2 2 1998

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

Mr. Davidson-Randell

Gabriel A. Berrebi , M.D. 15200 Shady Grove Rd. #305; Rockville, MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Daath Month Day William Dale DeWys 16, 1998 May 6:15 AM 4a Facility Nama (If not institution, giva streat end number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Bethesda Bethesda Montgomery if Under 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number Birthplaca (State or Foraign Country) 7. Aga (In vrs. last birthdev) 8. Date of Birth (Month, Dey, Year) Min. 1MM 2DF Months Days Hours 385-38-2558 58 Yrs Sept. 14, 1939 Michigan Usual Residence of Decedent 10d inside City Limits 10a Stata 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 United States 6830 Hillmead Road 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No if Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health Maintenance Elementery/Secondary (0-12) College (1-4or 5+) 5+ Organization Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Peter DeWys Jennie Morsink 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 6830 Hillmead Road, Bethesda, Maryland Alice Grace Schut DeWys/Wife 20b. Place of Disposition (Name of cemetery, crametory or other piece May 21, 1998 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarai Sarvice Licensae

Robert A. Pumphrey Funeral Home

Robert A. Pumphrey Fune Approximate Interval Between Onset and Death immediate Cause (Final Diabetic Foot Infection disease or condition resulting in death) Due to (or es a consequence of) Diabetes Mellitus Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lasf Due to (or es e consequence of): End Stage Diabetic Nephropathy Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Part ti, Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 210 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Dey Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 1 Naturai Injury 5 Pending 1 ☐ Yes 2 - No invastigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Straet end Number or Rurel Routa Number, City or Town, Steta)

physician end the burial-transit The law requires that the death certificete be axecuted 98 9SD signed by the e s certificate has b director, page 2 s director. After this funeral

Physician /Medical

Examiner

Examiner Physician/Medical þ Completed Be P Certification:

Medicai

4 ☐ Homicide

(Check only one)

31. Date filed (Month,

29b. Signatura and title of certifier

29a. Certifiar

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-1 ahow any Injury or other traumstic event, the Medical Examinet must be notified at

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, or Attanding Physician: death. ofter death Director: filled in

To the Fune completely f To the F within 2

Hospital 24 hours

State Registrar

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Day Year)

Physician

29c. Licanse number 050909

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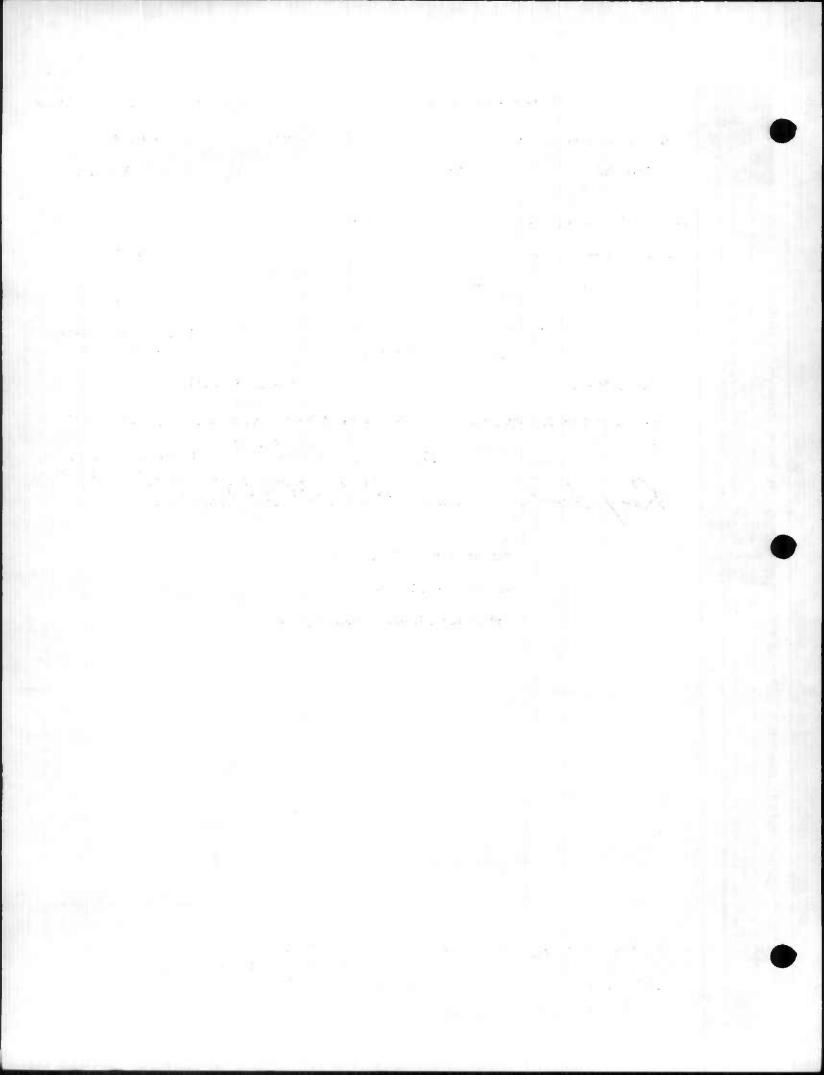
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d, Date signed (Month, Dav. Year) 18 98

Michele L. Marziano, M.D. 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Rock-ille

Lud 32 Registrar's Signature whia Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Month Day **Physician** 1)iem 2150 Adelaide May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) MONTGOMERY Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2ਊF Months Days 87 Dec. Pennsylvania Director 045-50-9423 Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show anothled at 1 Ves 2 □ No Maryland Gaithersburg Directo Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 2 any injury or other traumatic avent, the Modical Exercitive must be in United States 20877 301 Russell Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: p 3K Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) 20 Eva Burkett Edward Wolf 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) John E. Diem/son 2020 Short Street, New Orleans, Louisiana 20b. Placa of Disposition (Name of cemetery, crematory or other pleca) May 23, Date 1998 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Fundeal Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue ,M00803 Rockville, Maryland 20850-2805 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Deeth **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical 120013 **Examiner** Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of) 88 US6 signed by the a Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 □ Probably 4 Unknown per tension þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 s has 1 ☐ Yes 2 No certificata Hospital or Attanding Physician: 25. Was case referred to medical exeminer? director Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this funeral 28e. Dete of injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident after deati 6 Could not be determined 3 Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 124 hours 8 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29e. Certifier edical completely (Check only one)

State Registrar

31. Dete filed (Month, Day, Year)

Deepak

29b. Signature and title of cartifling

MAY 22

Sachdeva

32. Registrar's Signature Die Davidson-Randell

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) 5 hady

MD

29c. License number

9901

Grove

Medical

29d. Date signed (Month, Day, Year)

Rockville, Maryland

May

Adventist Hospital

Center Orive

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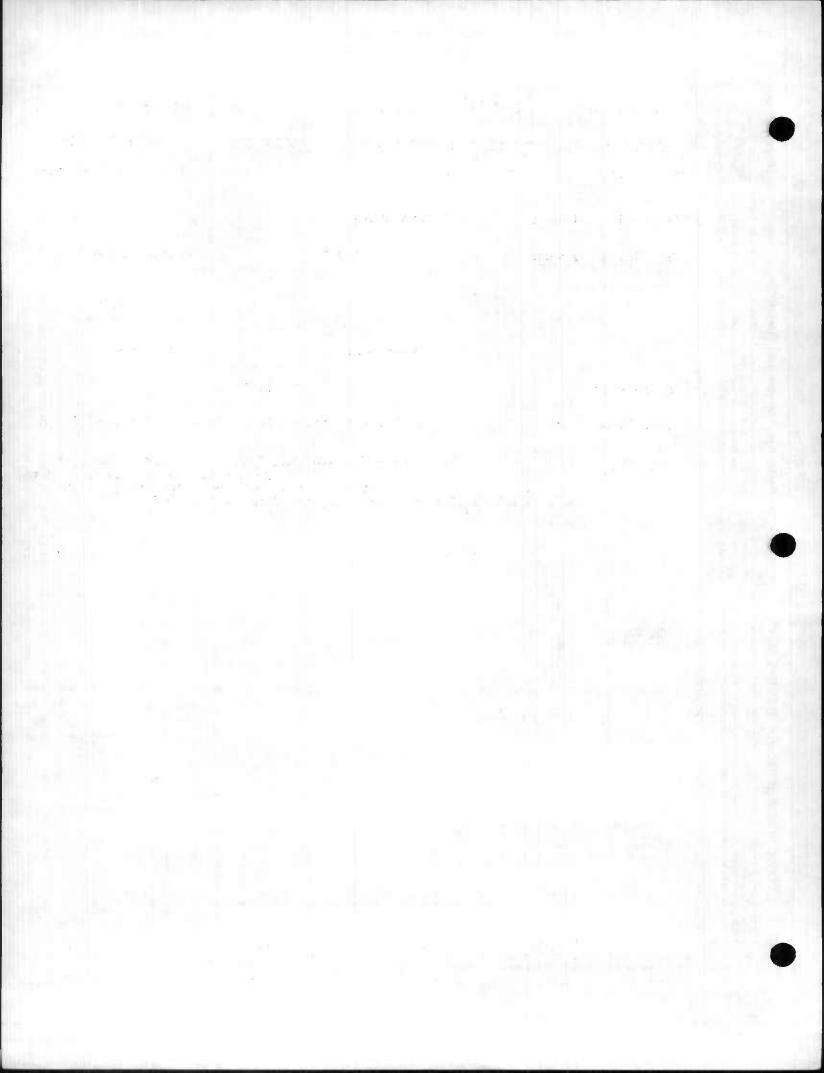
Baltimore, Maryland 21215-0020

requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Birus



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 14, Laurie K. Dine 1998 11:17AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 5 Social Security Number 7 Age (In vrs. last birthday) If Under 1 Year ff Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months 1□M 20 F Days Hours 092-12-0516 76 Director Sept. 12, 1921 Germany Usual Residence of Deceden with the Marylend 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Directo Dukes Massachusetts Vineyard Haven 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 55 Franklin Terrace 02568 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours after on of Health and Mantal Hygiena.
At: If Nem 27 is marked other than "natural", or Nei 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Midowed 4 Divorcad White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Kretzmer Lilli Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1341 Hemlock Street, NW, Washington, D.C. Kim C. Dine/Son 20b. Pleca of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other placa) May 18; 1998 0 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00198 er try lisease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final Lung Cancer l year disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner certificate be executed physicien and s the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) 98 USB ed by the a detached f 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 | Yes 2 | No 3 | Probably 4 | Unknown þ Records. 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy Completed been performed? **Dege 2** 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation Injury 1 X Natural il or Attending safter death. il Director: Aft 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

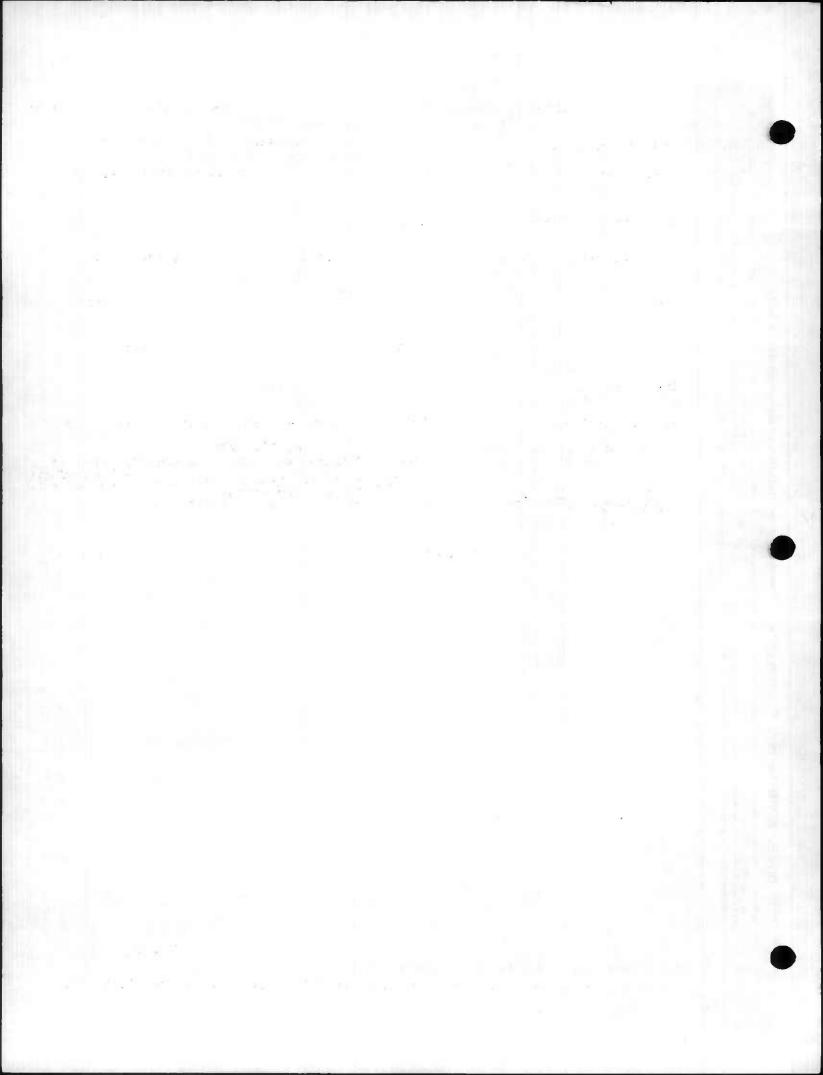
| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 10 May 16, 1998 D23600 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 5480 Wisconsin Avenue, #214, Chevy Chase, MD Bruce Kressel, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

MAY 1 9 1998

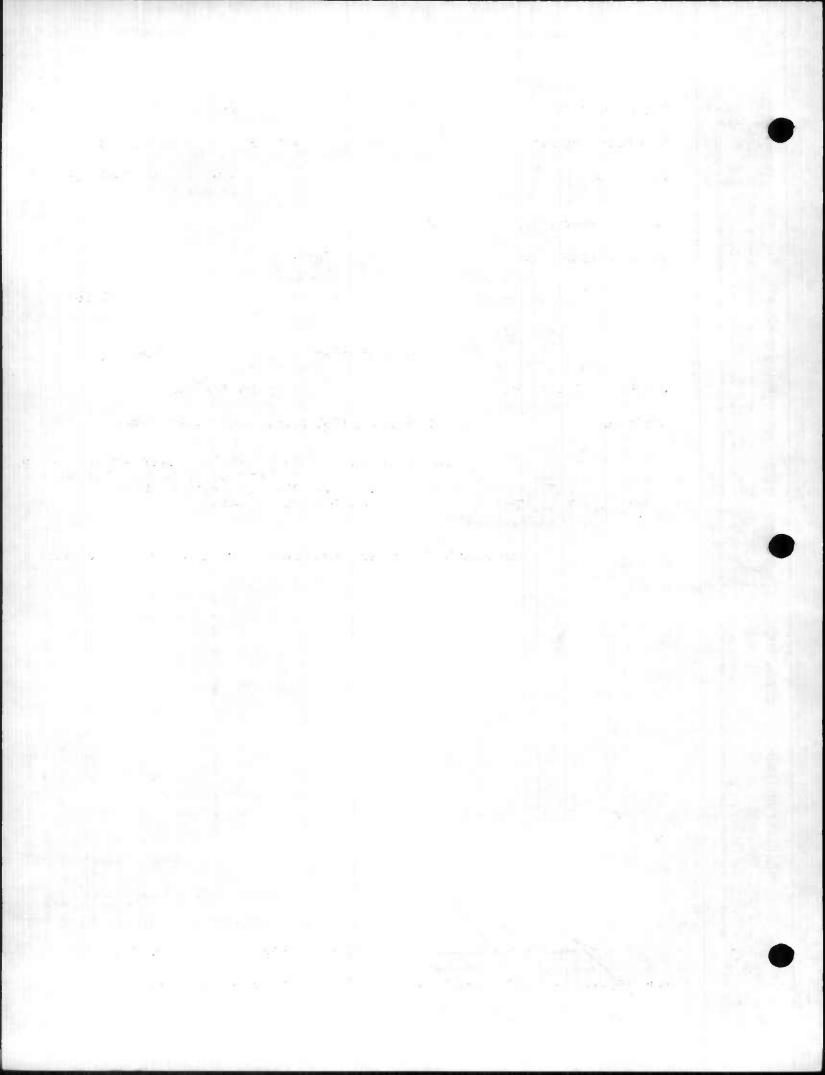
Lika Davidson

DHMH 16 Rev 6/95



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ical -	Stephen C. Duff							May		1998		7:15AM
iner	4a Facility Nama (ff not institution, give street and number)						b. City, Town, o	r Location of D	eeth	4c. County	of Death	
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Director	MD Montg	omerv	As	shton								1 ☐ Yas 2 ☒ No
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2	exeminer? 1 ☐ Yes 2 ☑ No 27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending	28e. Dete of Inj (Month, De	ury By Year)	Injury								
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2	exeminer? 1 ☐ Yes 2 ☑ No 27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident Investiga	28e. Dete of Inj (Month, Do		me, ferm, stra	М		Yes 2∐No		on (Stre		er or Rural	Route Number,
	exeminer? 1 Yes 2 \(\overline{\ove	28e. Pieca of Inbuilding, e	ijury - At ho tc. (Specify	me, ferm, stra	M et, factory	y, offica		City or	Town,	Steta)		
	exeminer? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending Investige 2 Accident Investige 3 Suicide 6 Could no determin 29e. Certifier 1 Certifying	28e. Dete of Inj (Month, Do	ijury - At ho tc. (Specify of my know of examinet	me, ferm, stra	M et, factory	y, offica	ne, dete end plec	City or	the ceu	Steta) se(s) and me	nner as sta	ted.
	exeminer? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending Investiga 2 Accident 3 Suicide 4 Homlcide 29e. Certifier (Check only 2 Medical E	28e. Dete of Inj (Month, D) tion t be ed 28e. Pleca of In building, e Physician: To the best taminer: On the basis of	ijury - At ho tc. (Specify of my know of examinet	me, ferm, stra	M et, factory occurred estigetion	et the tim	ne, dete end plec	City or	the ceu	Steta) se(s) and me	enner es sta end due to t	ted. he ceuse(s)
	exeminer? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending Investiga Investiga 3 Suicide 6 Could no determin 29e. Certifier (Check only one) 1 Certifying 2 Medical Estates	28e. Dete of Inj (Month, D) tion t be ed 28e. Pleca of In building, e Physician: To the best taminer: On the basis of	ijury - At ho tc. (Specify of my know of examinet	me, ferm, stra	M et, factory occurred estigetion	et the tim, in my of	ne, dete end pleo pinion, deeth occ	City or	the ceu	se(s) and me e end plece, e	enner as sta and due to t d (Month, D	ted. he ceuse(s) ey, Year)
Medical Certification: To B	exeminer? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending Investiga Investiga 3 Suicide 6 Could no determin 29e. Certifier (Check only one) 1 Certifying 2 Medical Estates	28e. Dete of Inj (Month, D) tion t be 28e. Pieca of In building, e Physician: To the best caminer: On the basis of and menner s	ijury - At ho tc. (Specify of my know of examinet	me, ferm, stra	M et, factory occurred estigetion 290 MT	et the tim, in my of	ne, dete end plec pinion, deeth occ a number	City or	the ceu	se(s) and me e end plece, e	enner es sta end due to t	ted. he ceuse(s) ey, Year)

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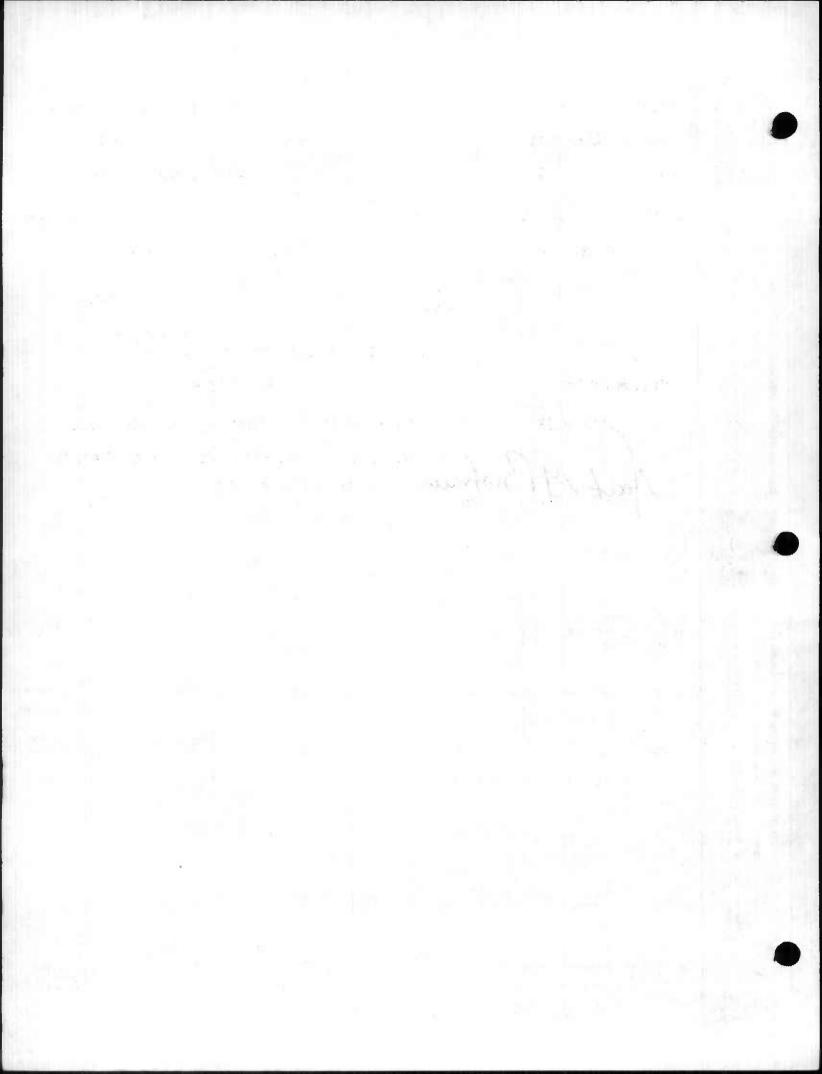


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 18, 1998 MAY **Physician** WALTER ATLAS DAWSON 4:48 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDER CARE LAPLATA CHARLES Months Days Hours Min. B. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiace (Stata or Foreign **Funeral** 1 M 2 □ F VIRGINIA 577-22-0757 79 Yrs Director Usual Rasidence of Decadent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director MARYLAND CHARLES MARBURY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 5284 BICKNELL ROAD 20658 U.S.A. 238 Funeral Herns 2 12. Was Decedent Ever in U,S. Armed Forces? 1 (X)Yes 2 □ No 1944 – If Yes, Give Year or Dates: 1945 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer tent of Heelth and Mentel Hygiene. nt: If frem 27 is marked other than "natural", or frei 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: WHITE Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retirad) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completed) DISTRICT OF COLUMBIA Elamentary/Secondary (0-12) Collega (1-4or 5+) ELECTRICAL SUPERVISOR GOVERNMENT 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM DAWSON LEVENIA DANSON 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OPAL N. DAWSON/WIFE 5284 BICKNELL ROAD, MARBURY, MARYLAND 20658 other 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Dr 20c. Location - City or Town, State 1 Donat Department of Important: If any injury or once. MARYLAND VETERANS' CEM. MAY 22,1998 CHELTENHAM, MD. 5 DOther (Specify) of Funeral Bervice THE HUNTT FUNERAL HOME, INC. G. BROHAWN M00053 MARK ' P. O. BOX 156, WALDORF, MARYLAND 20604 Part1. Inter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS disease or condition rasulting in daath) Examiner Examiner ULCER physician and s the buriel-transit that the death certificate be executed Sequentially list conditions, if any, laading to immediate ceusa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ohknown UROSEPSIS Records. 24b. Were autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy DEHYDRATION ALZEIMER, DESERSE 2189No AdVANCED 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was cese referred to medical examiner?
1 Yes 2 Ho Be 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding Investigation 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, offica bullding, etc. (Specify) Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicide edical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifier 29b. Signature and little of certifie 29c. License number D-44436 30. Name and address of person who complated ceuse of death (Item 23a) (Type, Print) 6B PRESTON SO II
ASHVIN KUMAL TRATCL MD INDUSTRIAL PARK DR 32. Registres Signature

8 July Shudson Randall 31. Date filed (Month, Day, Year) NAY 2 2 State 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month MAY **Physician** 1998 MARY EVELYN DE WITT 10:18 AM /Medical 4b. City, Town, or Location of Deeth 4e. Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** 5407 CORDWALL PLACE BELTSVILLE PRINCE GEORGE If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 8. Dete of Birth (Month, Dey, JANUARY 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Deys 1□M 2□F 1930 MARYLAND 68 579-36-6098 Yrs Director Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Director MARYLAND PRINCE GEORGE BELTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 23a F 5407 CORDWALL PLACE 20705 UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: If itsm 27 is marked other than "natural", or Itams 23a any injury or other traumatic event, the Medical Examiner mans Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American indien, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) 4 YEARS Elementery/Secondery (0-12) LICENSED PRACTICAL NURSE MEDICAL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be JAMES ALEXANDER FORD EVA HAWKINS FORD P 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JAMES O. DE WITT/ HUSBAND 5407 CORDWALL PLACE, BELTSVILLE, MARYLAND 20705 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Bunel 2 ☐ Cremetion 3 ☐ Removel from Stete FT. LINCOLN CEMETERY BRENTWOOD, MARYLAND 4 Donetion 5 Other (Specify) 5/26/98 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A. MASIA 16 THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. C. 20640 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel ckar ancer disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner physician and s the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to for es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): attending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Tyes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funersi Director: After this certific completely filled in by the funeral director, 25. Wes case referred to medical axaminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death Certification: 28b. Time of 28c. injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner steted. edical 29e. Certifier 29b. Signature and the of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) aus 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Suite 160 Hyatts ville MB 20782 6525 Belovet Rd Chalotte Kratt 31. Dete filed (Month, Dey, Year) 32. Registra's Signature State

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Registrar

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FT. L

THORNTON JOHNSON MC

State of Maryland / Department of Health and Mental Hygiene q

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1 Decedent's Neme (First Middle Last) Month **Physician** 17 /998 4c. County of Deeth 1710 may Dennis William Irvin /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | if Under 24 Hrs. | Months | Devs | Hours | Min. 5. Sociel Security Number Birthplece (State or Foreign Country) 6. Sex 1 AM 2 ☐ F 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys Hours Yrs 221-14-4285 Mar. 8,1916 Director Maryland Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s4 show other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with t 7263 Haywood Road 21851 USA Funerai death 12. Wes Decedent Ever in U,S.
Armed Forces?

1 (24Yes 2 □ No
If Yes, Give
Yeer or Detes: 14. Race - American indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or itel any Injury or other traumatic event, the Mexical Examinal Rice. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: PY 3 XWidowed 4 Divorced Black. Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 6th Laborer Farm 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) 2 Emma Calvin Dennis Sr. Frances Kelly 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7263 Haywood Rd., Pocomoke, Maryland 21851 Gary G. Collins, Sr. (son) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Cem. 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Burial 2 □ Cremetion 3 □ Removel from Stete Mt. Hope Baptist Church 5/22/98 Pocomoke, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Familian Survice Licensee 22. Neme end Address of Fecility Bennie smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock of hear failure. List only one cause on each line. **Physician** Immediete Ceuse (Finel diseese or condition resulting in death) /Medical minutes **Examiner** Due to (or ale consequence of): Examiner myocardial ician and bunal-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest es a consequence of): attanding physician for use as the buria Physician/Medicai Due to (or es e consequence of): 23b. Dtd tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably nknown 1 Yes 2 No þ 8 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No After this certificate funeral director, 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 10 No Impetient 2 ER/Outpetient 3 DOA Certification: To 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) Naturel 5 Pending 1 Yes 2 No death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 6 24 hours Scrifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as steted.

2 Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner stated. Medicai 29e. Certifier (Check only one) within 2 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Clayton Raab, M.D. 400 EasternShore Dr., Salisbury, Maryland 21801 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State

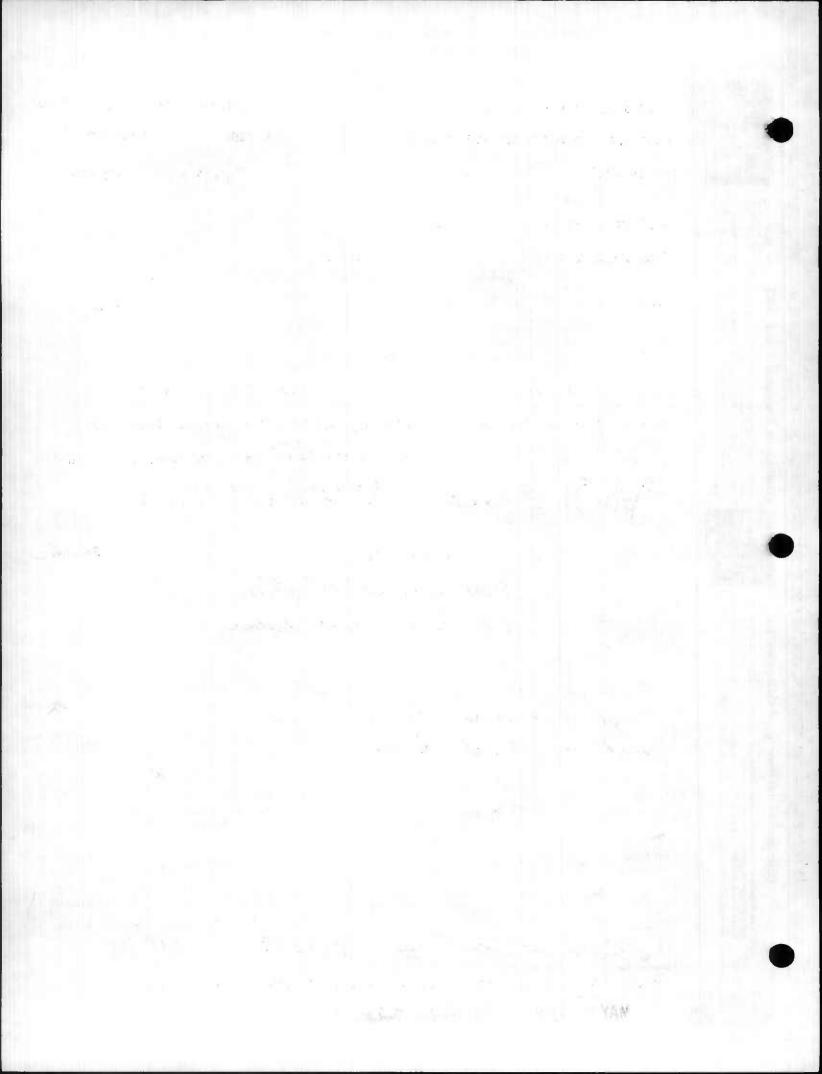
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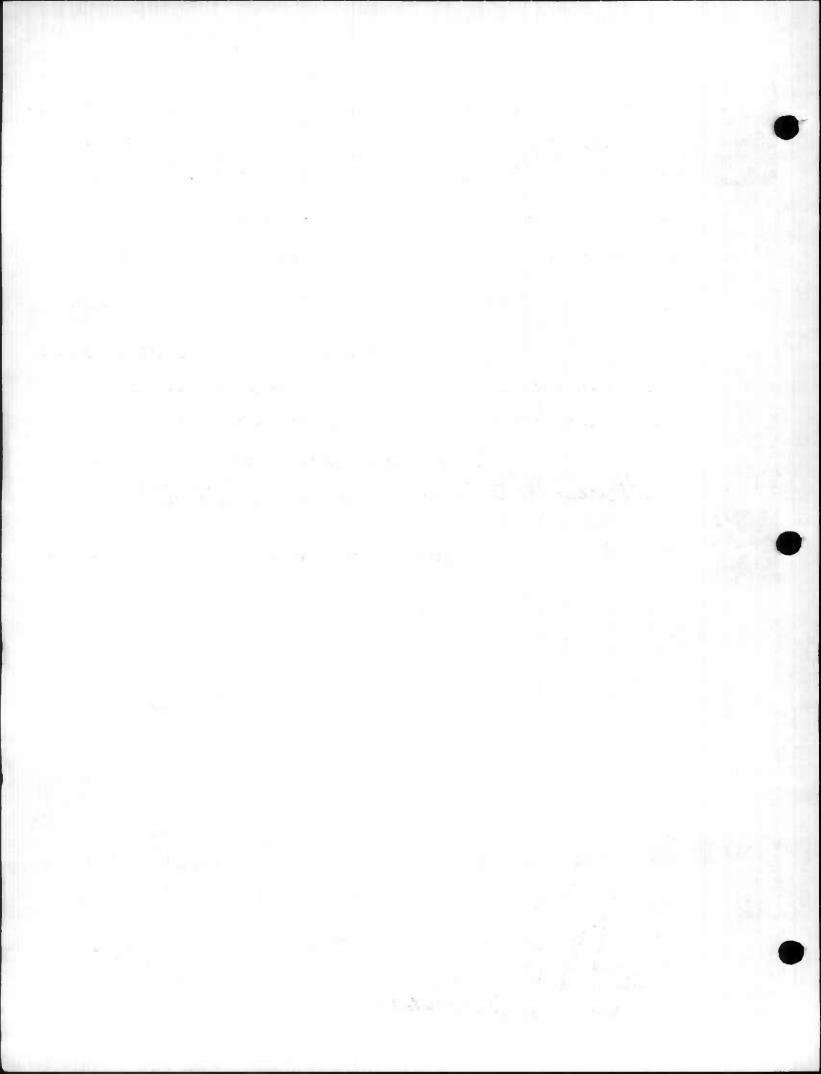
I. Dennis



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Death Month **Physician** 17, PAUL MYERS DAVIDSON 1998 5:05 AM MAY /Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 1800 HANOVER PIKE HAMPSTEAD CARROLL 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, EPT 7, Birthplace (Stata or Foreign Country) **Funeral** 1 € M 2 □ F Months Days Yrs. 219-12-2253 SEPT **Director** 86 MARYLAND Usual Rasidence of Decedent the Maryland a or 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits HAMPSTEAD 1 Yes 2 No Director MARYLAND CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with rne 23a 1800 HANOVER PIKE 21074 USA Completed by Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status "netural", or item filed within 72 hours efter 1 ☐ Yes 2 No tf Yes, Give Year or Datas: 1 ☐ Never Married 2 ☐ Married 21215-0020 1 Tas 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced WHITE The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuet Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry i Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) OUTDOOR ADVERTISING **FOREMAN** 9 .. Peges 1 and 2 should be filed w tment of Health and Mantal Hygier tant: If item 27 is marked other th lury or other traumatic event, in Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM BRADLEY DAVIDSON LORENA VIRGINIA MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) IRENE L. GORDON, DAUGHTER 20 IVY COURT, PERRINEVILLE, NJ 08535 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Pege Department of Important: If any Injury or GREENMOUNT UM CEMETERY 5/19 HAMPSTEAD, MD 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Renel Failure /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Physician/Medical Examiner pertus i The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or tnjury that initiated events resulting In death) Lest pue Due to (or as consequence of) P.O. Box 68760, the Due to (or as a consequence of): USB BSU Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to comptation of cause of death? Completed 24a. Was en eutopsy performed? page 2 certificate 1 Yas 2 No 1 Yes 2 No Division of Vital or Attending Physician: director. Be 25. Wes case referred to medical 26. Plece of Death (Check only one) examiner? 9 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this in by the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how tnjury occurred Certification: 28b. Time of 28c. Injury at Work? After 1- Natural 5 Pending Investigation death. 1 Yes 2 No i Director: / 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide To the Hospital within 24 hours en To the Funeral D 2 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my optnion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signatura and titled 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Neme end address of who completed ceuse of deeth (ttem 23a) (Type, Print) 2 111 Laroer like Hanfetul and 3 1000 x MO 31. Dete filed (Month, Day, Year) MAY 1 9 1998 State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Deta of Death 3 Time of Death Month Yeel **Physician** JUANITA EVELYN DEAN 20, 1998 10:20am May /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Center Allegany Cumberland 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. Date of Birth (Mooth, Day, Y Feb 18, 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Year) 1915 1□M 26 F Months Days Hours 83 Yrs. 214-07-2619 Director Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at Director Cumberland V Yes 2 No Allegany 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 13517 Primrose Street 21502 USA items 23a death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ŽŪ No Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. the Medical Examiner. should be filed within 72 hours efter of Mental Hygiene. marked other than "naturel", or item 1 ☐ Never Merrled 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: If Yes, Give Yaer or Dates: by 3€ Widowed 4 Divorced white Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Trevor Jones Emma (McKinney) 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Trevor L. Dean--son P.O. Box 521 Cumberland MD 21502 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremetion 3 ☐ Removel from State Sunset Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 05/22 Cumberland MD 21 Signeture of Funeral Saudica Licenses Name and Address of Eacility
Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one gause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disaesa or condition resulting in deeth) Examiner · Diabetic Nephrosclerosis 5 yrs. Due to (or es e consequence of): Examiner bunial-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest and Due to (or es e consequence of): Box 68760. physician Physician/Medical the Due to (or es e consequence of): attending 950 ö Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.0. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown Urosepsis Records, p 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed peen completion of cause of deeth? hes page 2 The certificate 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this cartifical leighly filled in by the funeral director. Be 25. Was case referred to medical exeminer? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Deta of Injury (Month, Dey Yeer) 27. Menner of Deeth 28h Time of 28c. Injury et Work? 28d. Describe how Injury occurred Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. Medical 29e. Certifier (Check only one) To the To the 29b. Signature an 29c. License number 29d. Data signed (Month, Dey, Year) D 14865 1998 21 May Jan 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Robustiano Barrera-Memorial Hospital Medical Center-Cumberland, MD 21502 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

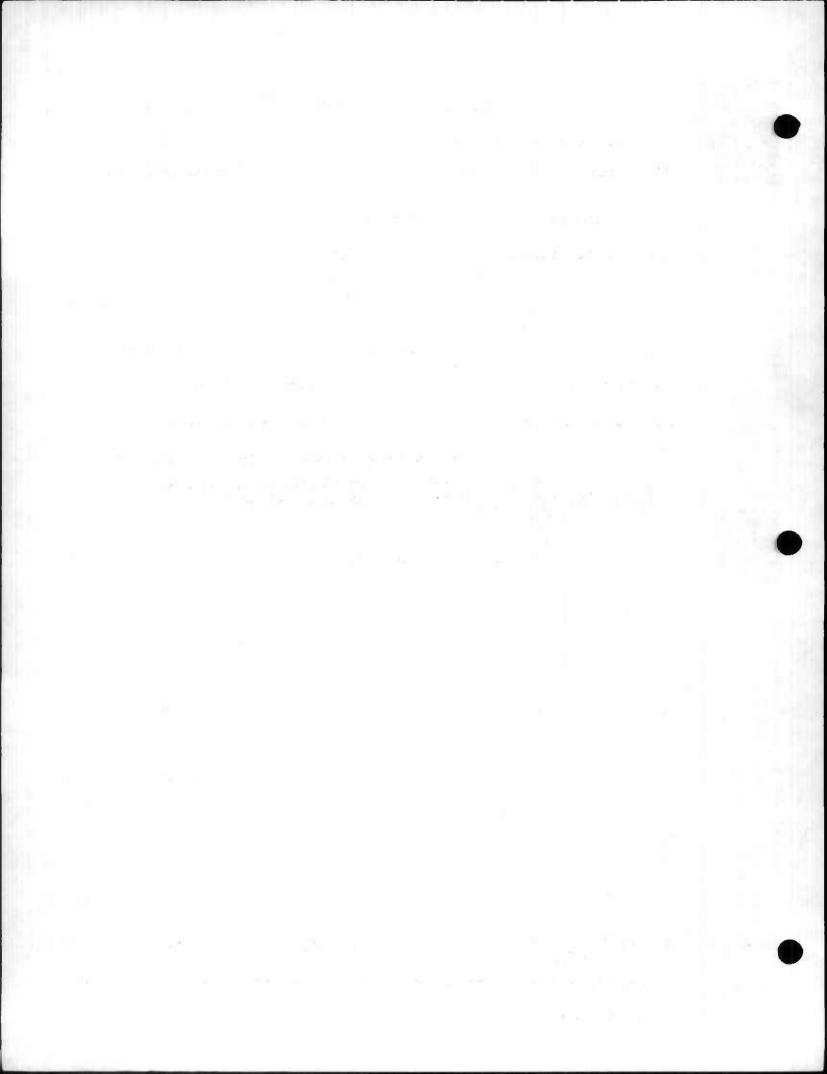
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State

MAY 21 1998

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Department Important: Fany injury o		21. Signature Finaral S	Sarvice Licer	Ada	m d)		22. Nama and Add Merritt-	,			1. 2150	2
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State

DAVID DOMBROSKI 208-42-4054

31. Data filed (Month, Day, Year) MAY 2 0 1998

30. Nema and addrass of person who completed causa of death (Itam 23a) (Type, Print)

29b. Signatura and title of certifia

Dr. V. Poonai, 922 National Hwy., LaVale, MD 21502

29c. Licansa number

D 36766

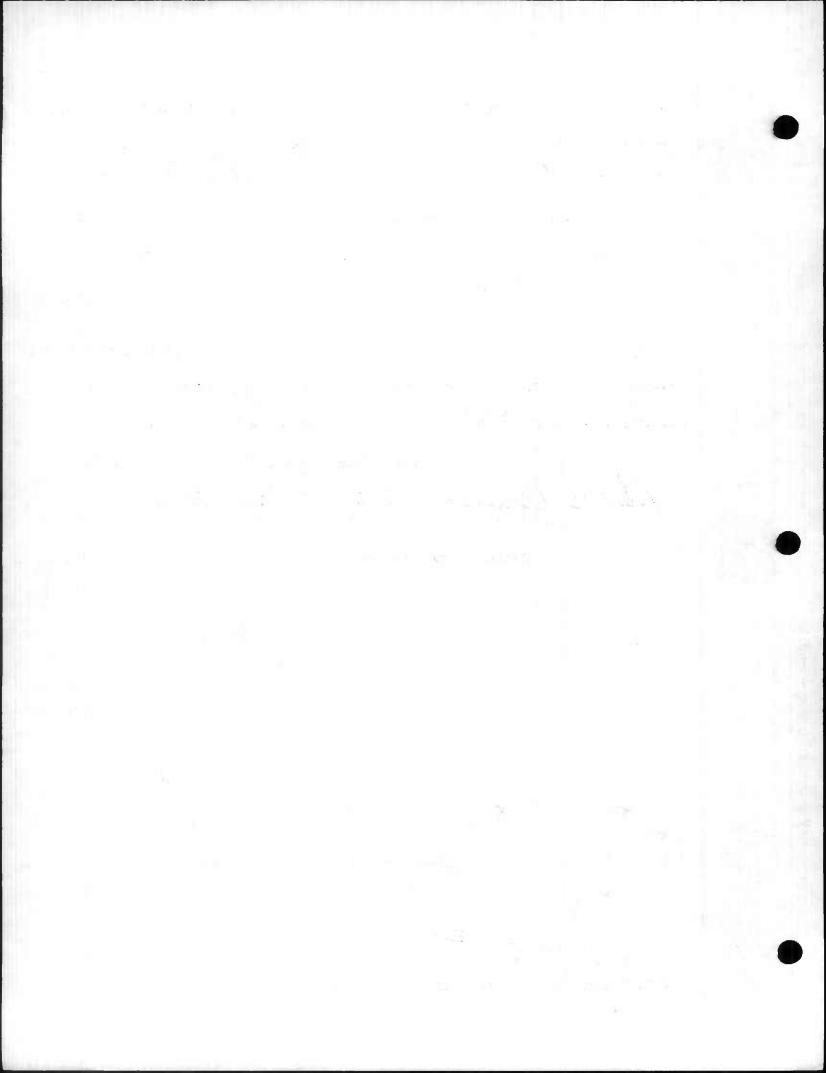
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1998

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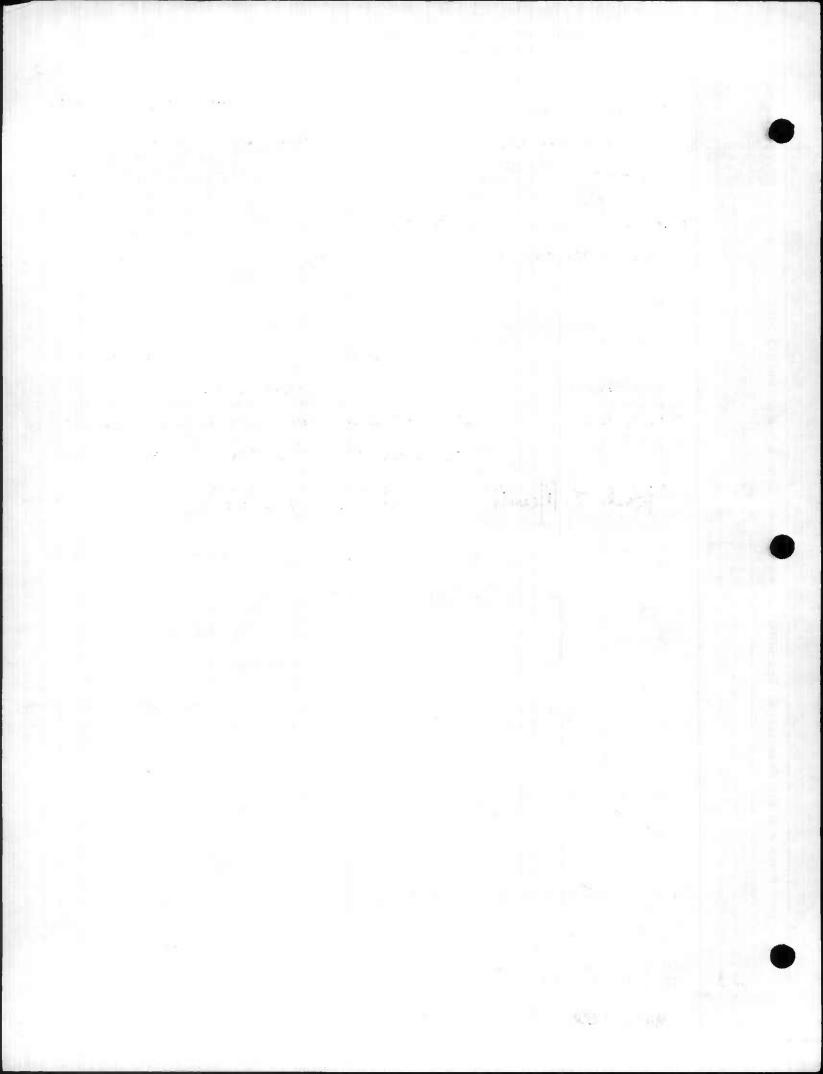
Registrar



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		Reg	. No.	6	1/0	29
	Bu laster		1. Decedent's Name (First, Middle, L	ast)					2. Date of Month	Death	Day	Year	3. Time	of Deeth
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Ř	Examin		4a Fscility Name (If not institution, g	ive street and number))			4b. City, Town	, or Location of D	eath	4c. County	of Death		
			SACRED HEART HO	SPITAL				CUMBE	RLAND		ALL	EGAN	Y	
	Funeral		Social Security Number 6.		ge (In yrs. las	t birthday)	If Under 1 Year Months Days		Hrs. 8. Date of	Birth Day, Y			lace (State	or Foreign
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			10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									ntry?		
	th w		17518 OLDTOWN F	OAD S.E.			21	555			U.	S.A.		
	ep # 5	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. W	/as Decedent of Yes, specify Cu	Hispanic Origin ban, Mexican, F	? (Specify Yes or	No-	14. Raca	a - Americ k, White,	can Indian, etc.	
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g		Bec	17. Father's Name (First, Middle, La	st)				18. Mother's	Name (First, Mic	ldie, Ma	iden Sumam	e)		
<u>a</u>	should be of Mentel marked o	0	JACK ROBINETTE					MARG	ARET BEN	N				
Maryland	AS DE P		19a. Informant's Name/Relationship	(Type, Pnint)		19b. Mailin	g Address (Street	et and Number	or Rural Route Nu	mber, C	City or Town,	State, Zip	Code)	
	nd 2 lith a 27 to		PAUL M. DURR		SON 1	7518	OLDTOWN	ROAD S	.E. OLDT	OWN.	MARY	LAND	2155	5
ē,	other tra		20a. Method of Disposition		20b. Plac	a of Dispos	ition (Name of atory or other p		Date	_	c. Location -			
Baltimore,	permit. Peges Department of Important: If he eny Injury or of		1 Burlal 2 Cremetion 3 4 Donation 5 Other (Spec	cify)		T CEM	ETERY	MAY 18	1998	CUN	MBERLA	ND MA	ARYLA	ND
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	Examiner		disease or condition resulting in death)	θ	SEPTI	C	SHOCK	57	NOROM	6			24 4	142
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State of Maryland / Department of Health and Mental Hygiene

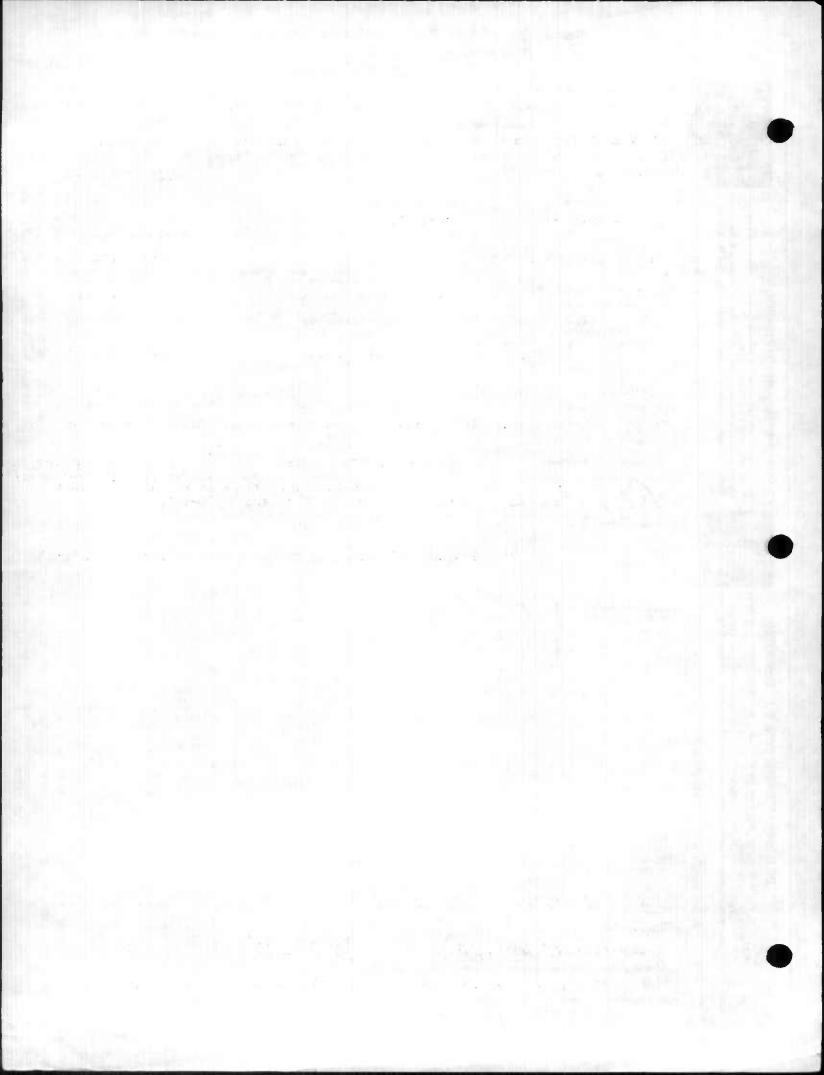
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Physician /Medical	Wilfred Russe	11	Ehrmantra	aut		0, 1998		12:17 PM	
Examiner	4a Facility Nama (If not institution, give str	set end number)		4b. City, Town, or	Location of Daeth	4c. County	of Death		
	11606 Magruder La	ne •		Rockvi		_	omery		
uneral irector	5. Social Security Number 6. Sax 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Aga (In yrs. la 72	st birthday) If Undar 1 Y Yrs. Months Di	aar If Under 24 Hrs ays Hours Min.			9. Birthplec. Country) Mary La	a (State or Foreign nd	
	Usual Rasidance of Decedent								
a how	10e. State 10b. County		Town or Location				10d.	Insida City Limits 1 ☐ Yas 2 No	
notred a	Maryland Montgomery	Rocl	kville						
or 2	10e. Street end Number		10f. Zip Co	da		10g. Citizan of W	/hat Country	?	
23. ral	11606 Magruder Lan	е	208			United :			
"naturel", or items 23s or 28s-f si bottes Exercise must be notified leted by Funeral Director	11. Marital Stetus 12 1 Naver Married 2 Married 3 Widowed 4 Divorced	Wes Decedent Evar in U,S Armed Forcas? 1 ⊠ Yes 2 □ No If Yas, Giva Year or Dates: WWII	13. Was Decedant if Yas, specify	of Hispanic Origin? (S Cuban, Maxican, Puar No <i>Specify:</i>	Specify Yes or No- to Rican, atc.)	Specify.	e - American k, Whita, atc Whit		
te par	15. Decedant's Educe	tion (manufactor)	16a. Decedent's Usual O	ccupation one during most of wo	deina	16b. Kind of Bu	siness/Indus	try	
	Elementery/Secondary (0-12)	Collaga (1-4or 5+)	life. DO NOT use re	etired)	rang				
omp	, (, , , , , , , , , , , , , , , , , ,	5+	Physic	ian		Inter	nal Me	edicine	
aumatic event, pra M To Be Comp	17. Fathar's Neme (First, Middle, Last)			18. Mothar's Ne	me (First, Middle,	Maiden Sumam	e)		
	John Myron Ehrma	ntraut		Madge	Ivey				
traumatic To	19e. Informant's Name/Relationship (Type	, Print)	19b. Melling Addrass (St			er, City or Town,	State, Zip Co	ode)	
P 2	Evelyn W. Ehrmantr	aut/Wife	11606 Magru	der Lane,	Rockvill	e, Mary	land 2	0852	
otho	20a. Mathod of Disposition	0.00	ace of Disposition (Name of metery, cremetory or other	of	Date	20c. Location -			
8	1 Burial 2 Cramation 3 Ran 4 Donetlon 5 Other (Specify)	novel from State	e of Heaven	May 4	3, 1998	Silver Sp	and an a	Manual and	
undu .	21. Signatus of Funaral Sarvice Licensea	Gatt			hert A	Pumphre	THE,	ral Home	
Important: If Item 2 any Injury or other once.	To Talana Salvico Cicolista	,	Rockvill	ddress of Facility Ro	00 West	Montgome	ery Av	enue	
	Kouf Jou	M0019	8 Rockvill	e, Marylan	d 20850-	2805			
	23a. Part1. Enter the disaasa, or complica shock or heart failura. List only one	tions that causad tha daath. causa on aach lina.	Do not anter tha mode of	dying, such as cerdia	c or raspiratory ar	rrast,	i In	pproximata terval Batween	
/sician							0	nsat and Death	
edical	Immediata Causa (Final diseese or condition	Glioblastom	a Multiforme	of the le	ft Front	al Lobe	13	Months	
miner	rasulting in daath) e.		as e consequenca of):						
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Ca Ca	that initiated avants	Due to (or	as a consaquance of):						
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Physician/Mec									
detached	Part II. Other significant conditions contri	buting to death but not rasul	ting in the underlying caus	a givan in Part I.				e cause of death	
					10	Yee 210 No	3 Probat	oly 4 Unknow	
S S S					24a Was	an autopsy	24b. Wara	autopsy findings	
cate has been signe, page 2 should be c					parlo	rmed?	availa	bla prior to lation of cause	
has by 2 s mpi							of de	eth?	
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director, par fo Be Co	25. Wes case rafarrad to medical axaminar?			26. Placa of Da	ath (Check only o	one)			
To F	1 Yas 2 No Hos	spital:	R/Outpatient 3 DOA	Other: 4 Nursing	Homa 5 Pasi	dence 8 Oth	ar (Specify)		
	27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Time of 28c.	Injury at Work?	28d. Dascribe	how injury occur	ed		
tun tio	1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant invastigation	(Month, Day Year)	Injury M	1 Yas 2 No					
al Director: After the din by the funeral Certification:	3 ☐ Suicida 6 ☐ Could not be	28a. Plece of Injury - At hor	me, farm, street, factory, of	fice		Street and Numb	er or Rural R	loute Number,	
Direct d in by	4 Homicida	building, atc. (Specify)			City or To	wn, State)			
To the Funeral Completely filled		lan: To the best of my know r: On the basis of axamination							
Mec Mec	200 Seature and title of certifier	and ingelier stelet.	29c 1i	cense number		29d. Data signe	d (Month. Da	y, Year)	
-8	Na. / D.	· · · · · · ·	N	17701		- Company			
*	james 40171	sery (ML)	リリ	04787		May 2	1, 199	8	
	30. Sama and addrass of person who com								
	James A. Brown, M.D		23a) (Type, Print) cord Street	#300, Kens	ington,	Maryland	1 2089	5	

State Registrar

MAY 2 2 1998

31. Dete filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Day Month Year 20, 1998 6:45pm Emrick May 4b. City, Town, or Location of Deeth 4c. County of Death Silver Spring Montgomery If Undar 1 Yaar 6. Sax

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "patural", or items 23a or 28a-f ehow eny injury or other traumatic event. the Maryland or other traumatic event.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician end the burial-transit use as jo signed by the a 8 page 2 has certificate director

The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: After this funeral after death. Director: Aft filled in by 24 hours a completely within 2 To the

Physician I. Constance /Medical 4e Fecility Nama (If not institution, giva street and number) **Examiner** Mariner Health of Silver Spring Hours Min. MARCH 7, 19 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1□M 20 F Months Days 1905 ILLINOIS 326-07-4223 Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yes 2 PNo MD MONTGOMERY SILVER SPRING Directo 10e. Street and Number 10f. Zip Coda 10g, Citizen of Whet Country? 9411 CAROLINE AVE. 20901 USA Funeral 12. Wes Dacedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, atc. 1 ☐ Yes 2 ☐ No If Yas, Giva# # Yaar or Datas: 1 □ Nevar Married 2 □ Married 1 ☐ Yas 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) BOOKEEPER FURNITURE 18. Mothar's Nama (First, Middla, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) JOHN R. BRADFORD CLAIRE WELLS 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) (DAUGHTER) JUDITH LEESE 9411 CAROLINE AVE. SILVER SPRING, MD 20901 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from State FORT LINCOLN CREMATORY 5-24-98 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nema and Addrass of Fecility HINES-RINALDI 11800 NEW HAMPSHIRE 21. Signature of Funeral Service Licensee AVE. SILVER SPRING, MD 20904 23a. Part 1. Entar tha disaasa, or complications that causad tha daath. Do not antar the moda of dylng, such as cardiac or raspiratory arrest shock, or haan failura. List only one causa on aach lina. Approximata intarval Between Onsat and Death Immediata Causa (Final a ACUTE MYOCARDIAL INFARCTION MINUTES disaasa or condition rasulting in daath) Dua to (or as a consequence of) Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as e consequança of) Physician/Medical Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No CHRONIC OBSTRUCTIVE PULMONARY DISEASE þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yas 2 PNo 1 Yas 2 No 25. Was casa rafarrad to medical Be 28. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No 10 28a. Data of Injury (Month, Day Year) 28c. injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: Injury 1 [Natural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) 29a. Cartifiar Medical (Check only one)

29c. License number D06674

29d. Data signad (Month, Day, Year)

5-21-1998

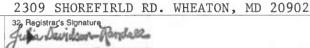
State Registrar

31. Data filad (Month, Day, Year)

MYRON L. LENKIN M.D.

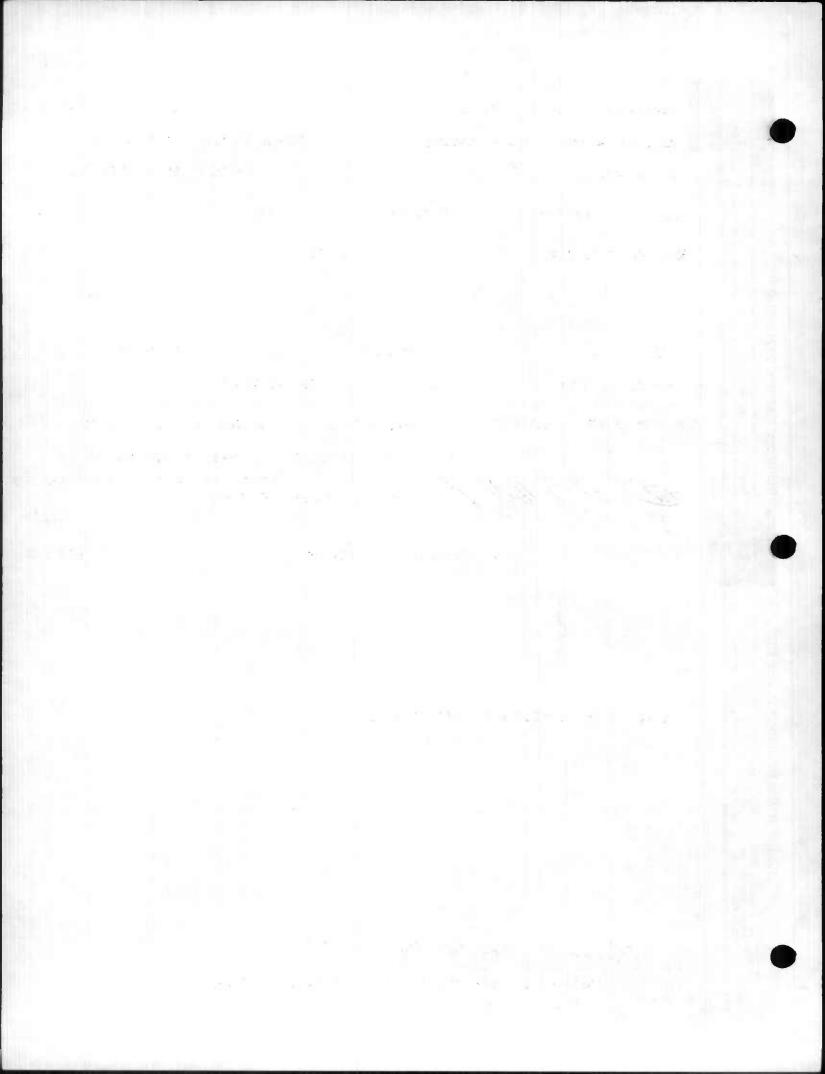
29b. Signetura end titla of certifiar

MAY 2 2 1998



and mennar si

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

physician and the buriel-transit that the death certificate be executed Box 68760, P.0. á signed be det Records. page 2 s 368 Division of Vital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death **Physician** ELIZABETH M. EATON MAY 13, 1998 1:55 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 29160 Krismor Court, Rayland Acres Trappe Talbot If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 M 200F Months Days Yrs. 220-12-1641 93 Director Nov. 5, 1904 Easton, MD Usuel Residence of Decedent deeth with the Maryland 10a. State ahow 10b. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumetic event, the Medical Examena must be notified at Director XXYes 2 No Talbot Maryland Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Tred Avon Avenue 21601 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ②XNo
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc. Peges 1 and 2 should be filed within 72 hours after on or of Health and Mental Hydinea.

It from 27 is marked other than "natural", or the iny or other traumatic event, ire Medical Examines iny or other traumatic event, ire Medical Examines. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes Specify: Specify: py 3 √ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be William C. Meintzer Florence Birch 19a. Informant's Name/Reletionship (Type Print) onal Representation Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara K. Eaton/Daughter-in-law 29611 Dover Road, Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery/May 16, 1998 Hillsboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, Maryland 21601
23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest,
Approximate Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final manoma disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? MMI 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed memia Atheroscherote 20X No 1 Tyes 1 Yes 28 No dospital or Attending Physician: TI
4 hours efter death.

"uneral Director: After this certificate
ely filled in by the funeral director, pr Be 25. Was cese referred to medical examiner? 28. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1□ Yes 2 No Other: 4 | Nursing Home 5 | Residence 600 Other (Specify) CARE HENE Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in 24 hours.
The Funeral Director of the Funeral Direc 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide edical 29a Certifier 🔀 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of county 29d. Dete signed (Month, Dey, Year) 30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print) Dutchman Lone 10 uyne 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Lulia Davidson MAY 18 Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 8

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth May 14, 1998 **Physician** 9:56 PM Charles Edward ESWORTHY /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Frederick Frederick Frederick Memorial Hospital Hours Min. 8. Date of Birth Follow, Day, 1922 5. Sociel Security Number If Under 1 Yeer 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2□ F Months Days Maryland 214-16-1879 76 Yrs. Director Usual Residence of Decedan filed within 72 hours efter death with the Maryland I Hygiene.
Ther than "natural", or flema 23a or 28a-f show ent, the Modical Examiner must be notified at 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Maryland Frederick Frederick Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 437 Center Street 21701 U.S.A. Funeral 12. Was Dacedent Ever in U.S. Armed Forces? NOXYes 2 □ No If Yes, Give Year or Detes: 1943–1946 Was Decedent of Hispenic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Bieck, White, etc. 11. Marital Status 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ ₩idowed 4 Divorced Completed 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Finance Officer Government marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 end 2 should be f nent of Heaith and Mental I nt: If item 27 is merked of **ESWORTHY** PHLEEGER John Elsie 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Brian M. Esworthy, Son 7203 Paddock Court, New Market, MD 21774 if item 27 or other t 20b. Pieca of Disposition (Neme of cemetery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If ony injury or once. Mount Olivet Cemetery, May 18, 1998 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Keeney and Basiord P.A. Funeral Home M00255 106 East Church St., Frederick, MD 23e. Part 1. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiretory errast, shock, or heart tellura. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medicai Immediate Cause (Final ar-hythmas acute Cardiac diseese or condition rasulting in death) Examiner Due to (or as a consequance of): Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest Due to (or es e consaguanca of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): attending pl Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detech-1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evallable prior to Completed 24e. Wes en eutopsy performed? completion of cause of daeth? this certificate has ral director, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifical stelly filled in by the funeral director, p Be 25. Wes case referred to medical 26. Piece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Secertifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the causa(s) and mannar as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and menner stated. 29a Certifier Medical 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) D 14626 May 15, 1998 30. Name end address of person who completed cause of deeth (item 23e) (Type, Print) P. Gregory Rausch MD 501 West Seventh Street, Frederick, MD 21701 31. Data filed (Month, Dey, Yaar) State Sali Davidson Rentall Registrar

DHMH 16 Ray 6/95

JEH JAAN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician
/Medical
Examiner

Funeral

Director

the Maryland "natural", or items 23a or 28a-f show death Pages 1 end 2 should be filed within 72 hours efter of neart of Health and Mental tyglene.
Int: fittem 27 is marked other than "natural", or ital
Inty or other traumatic event, the Medical Engine

Baltimore, Maryland 21215-0020

Department of Important: If any injury or **Physician** /Medical **Examiner**

Physician/Medical Examiner

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Completed

Be

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Certification:

Medical

or Attending Physician: The law requires that the death certificate be executed buriel-transit pur Division of Vital Records, P.O. Box 68760, the been signed by should be detac Aftar this certificate has To the Hospital or Attending Phy within 24 hours aftar death. To the Funeral Director: Aftar this completely filled in by the funeral (

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 920 Am Month telen Z. 05 4a. Fecility Neme (If not institution, give street end number 4b. City. Town, or Location of Death 4c. Counfy of Deeth Chestertown Nursing & Rehabilit. Center Chestertown
| If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yaer) 5. Sociel Security Number Year 7. Age (In yrs. lest birthdey) Birthpleca (State or Foraign Country) Deys 1 ☐ M 2 🕏 F Months Vre 097-05-4116 83 Maryland Usual Residence of Decedent 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yas 2 ☐ No Maryland Queen Anne Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 101 Chester View Funeral 21620 U.S.A.

14. Rece - American Indian, 12. Was Decadent Evar In U,S. Armad Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Detes: 11. Maritel Status Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puento Rican, etc.) Bleck, White, etc. 1 □ Never Merried 2 □ Merried 1 ☐ Yes 2 ☑ No Specify: Completed by 3X Widowed 4 □ Divorced Specify: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) hair stylist beauty shop 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Fred Zlock Marie Vashrick Zlock 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code 19808 19e. Informent's Neme/Relationship (Type, Print) Dorothy H. Eskridge/niece 9 Michael Ct. Rhinestone Hills W. Wilmington, DE 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Greensboro Cemetery 5/16 Greensboro, Maryland 21. Signature of Fungral Sarvice Licansee 22. Name end Address of Fecility Fleegle & Helfenbein Funeral Home, P.A. 23a. Fath. Enter the disease, or complications the daysed the death. Do not enter the mode of dying, such as cardiac or respiratory enest, shock, or heer feiture. List only one cause on each line. Arterios de rotic Cardiovas cular Disease Immediete Ceuse (Finel disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown Renal Failure, Chronic 24b. Were eutopsy findings evellabla prior to completion of cause of deeth? 24e. Wes an eutopsy parformed? Left Cereprovascular Accident 1 Yes 2 No 1 Tyes 2 No. 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 20 No Other: Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29b. Signetura and title of certifier 29c. Licensa number D17036- Ma. K, Roo, mo.

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

516 Weshing for Hore. Chestnoon Mid 21620 DUSANK. Ross, m.D. 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year)

State Registrar

Julia Devidor - Fundass

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Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #20b, 5/20/98, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 2130 Month **Physician** FRANCIS FARREU 1998 MAY /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HOLY CLOSS HOSPITATI SILVER SPRING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Deys Hours 15 M 2□ F Months 81 New York 074-16-6849 March 4, 1917 Director Usual Residence of Decedent the Manylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after deeth with the Maryle nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23s or 28s-f show with the worder traumatic event, in Medical Example must be notified as 1 TYes 2 TNO Director Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20902 11717 Stonington Place USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 W Yes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 1942-62 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Psychologist Behavioral Science 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) John Farrell Mary Rooney 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Clare L. Farrell (wife) 11717 Stonington Place, Silver Spring, MD 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. West Home, Inc. Hun low Silver Spring, MD 20901 MADOS 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** MYOCARDIAL ENFRACTION /Medical immediate Ceuse (Final ACUTE disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) attending pl ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p Sign 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an eutopsy Completed certificate hes tirector, page 2 s 1 □ Yes 2 No 1 ☐ Yes 2 12 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this funeral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident n 24 hours after des Ne Funeral Director pletely filled in by th 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated. Medical

To the Hosp within 24 hor To the Fune completely fi

10+1

State

Registrar

31. Date filed (Month, Day, Year)

(Check)

29b. Signatu

MAY 1 9 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title of certifier

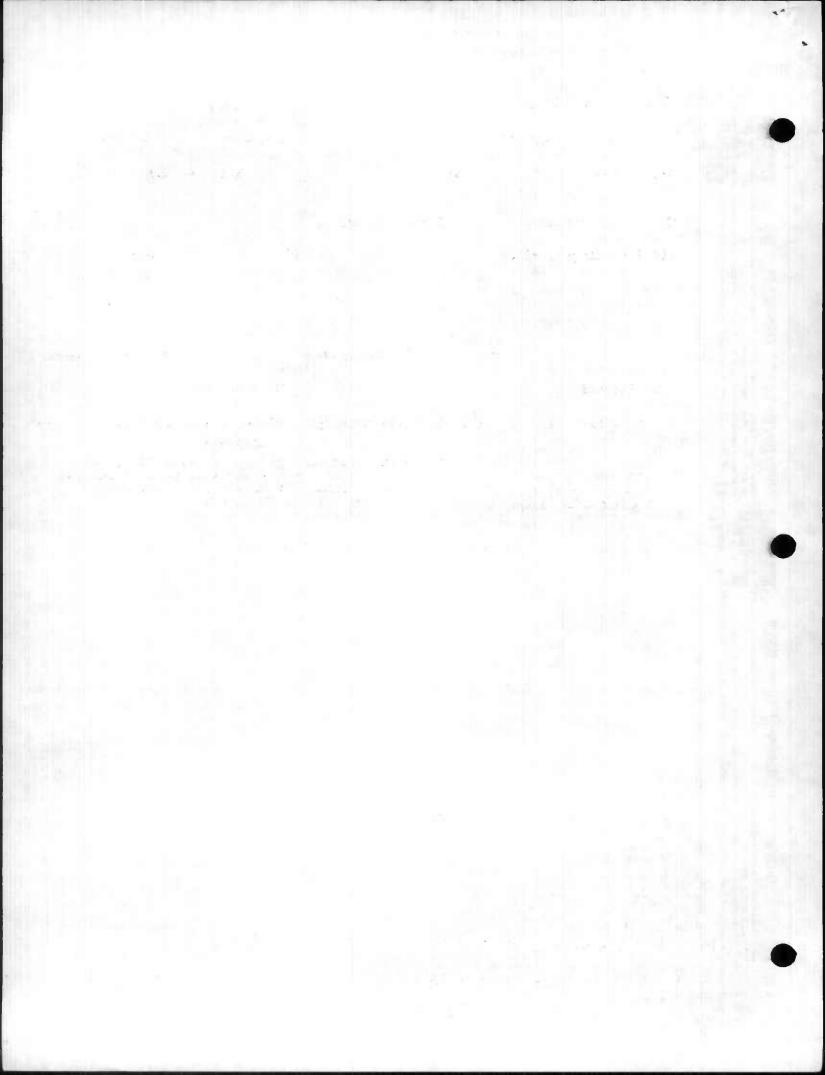
THE I MARGOUI, M. O. 11/25 POCKULUS PLAT, PLOCKULUS, MO 20852 32 Registrar's Signature Julia Davidson-Randell

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

DME

29d. Dete signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth Month MAY ARC **Physician** 2/15 CHRISTOPHER /Medical 4c. County of beath 4b. City, Town, or Location of Deeth 4a. Facility Nama (If not institution, give straat and number) Examiner Chestnut Lodge Rockville Montgomery H Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dev. Year) | 9. Birthplace (State or Foreign (Month, Dev. Year) | April 27, 1964 | New York 5. Social Security Number 7. Age (in yrs. iast birthday) Funeral 1⊠M 2□ F Director 226-82-7954 34 Usual Rasidance of Dacedent 10a. State 10c. City. Town or Location 10b. County r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Insida City Limits 1⊠ Yes 2□ No Director Maryland Montgomery Rockville 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 500 West Montgomery Avenue 20850 United States 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give 11. Marital Status 14. Race - American Indien, Black, Whita, atc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yas 2 No Specity: py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Eiamantary/Secondary (0-12) Coilega (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygian Important: If Item 27 is marked other that any Injury or other transmitted. Student None 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Meiden Sumama) Be Rocco Roberto Fazio Doris Mae Pengelly 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Rocco Roberto Fazio/Father 3026 Buchanan Street, San Francisco, CA 94123 20b. Place of Disposition (Nama of cematary, cramatory or other place) May 19, 1998 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cramation 3 ☐ Ramovei from Stata 4 □ Donation 5 □ Othar (Spacify) Bethesda, Maryland Montgomery Crematorium, Inc. 22. Nama end Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Pumphrey Funeral Home/ Rockville, Inc. M00689 Rockville, Maryland 20850 , or complications that causad the deeth. Do not entar tha moda of dying, such as cardiac or respiretory errast, List only one causa on aech lina. Approximate Intarvai Between Onset end Death **Physician** ASPMYXIA /Medical tmmediete Ceusa (Final disaasa or condition rasulting in death) **Examiner** Examiner The law requires that the death certificete be axecuted physician end is the bunal-trans Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in daeth) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consaquenca of): P.O. Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Vunknown ABUSE RUG signed d be dat Records, þ 24b. Wera autopsy findings availabla prior to complation of cause of daath? Be Completed 24a. Was en eutopsy performed? ata hes 20 No 1 Yas 1 ☐ Yas 2 ☐ No certificata Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical letaly filled in by the funeral director. 25. Was case referred to medical 26. Pieca of Death (Check only ona) axaminar? Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To Yas 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Day Yaar) 27. Mennar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding MAY 15-98 1 Yas 2 No HUNG FROM 2 Accident invastigation WOO K 3:☐ Suicida 4 ☐ Homicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Thobas 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Spacify) ITANGING M Medicai 29a. Cartifian 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mennar es stated. To the Hosp within 24 hou To the Fune completaly fi (Check only one) 25 Medical Examiner: On the basis of exeminetion end/or invastigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29d. Data signed (Month, Day, Year) (item 23a) (Type, Print) 10215 FERNWOOD RD BETHERD.

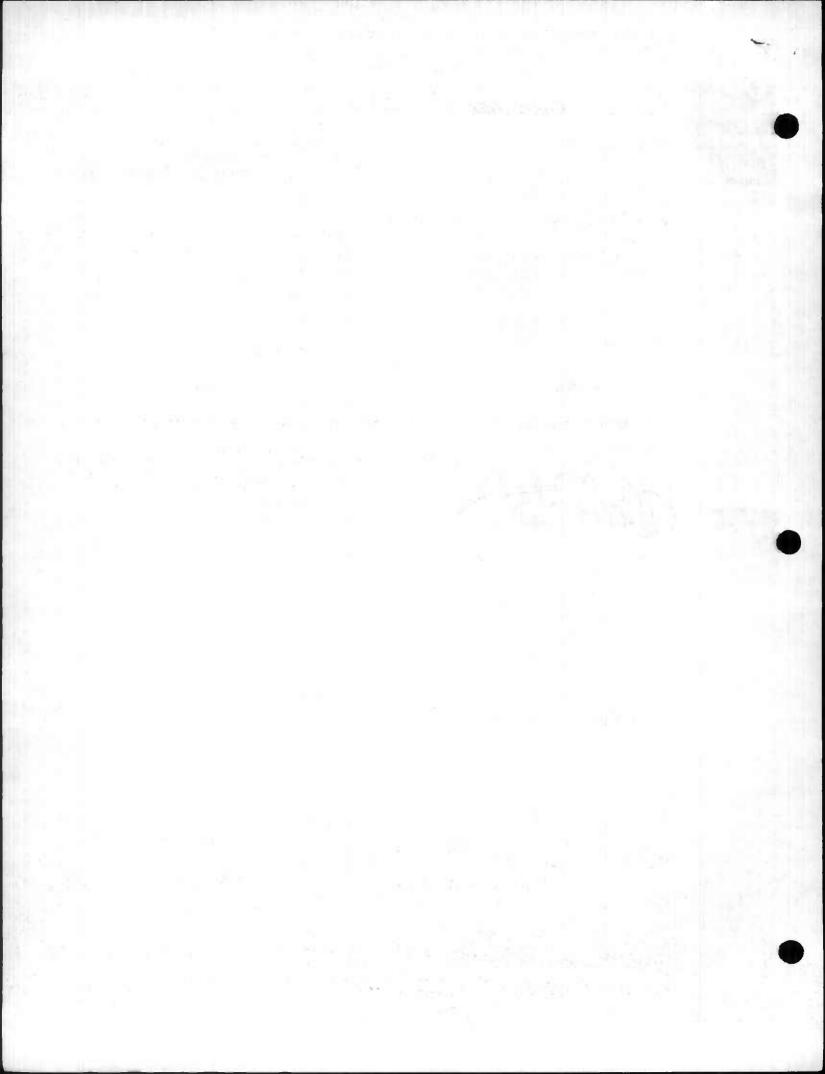
Registrar's Signature

Julia Davidson

State Registrar 31. Data filed (Month, Day, Year)

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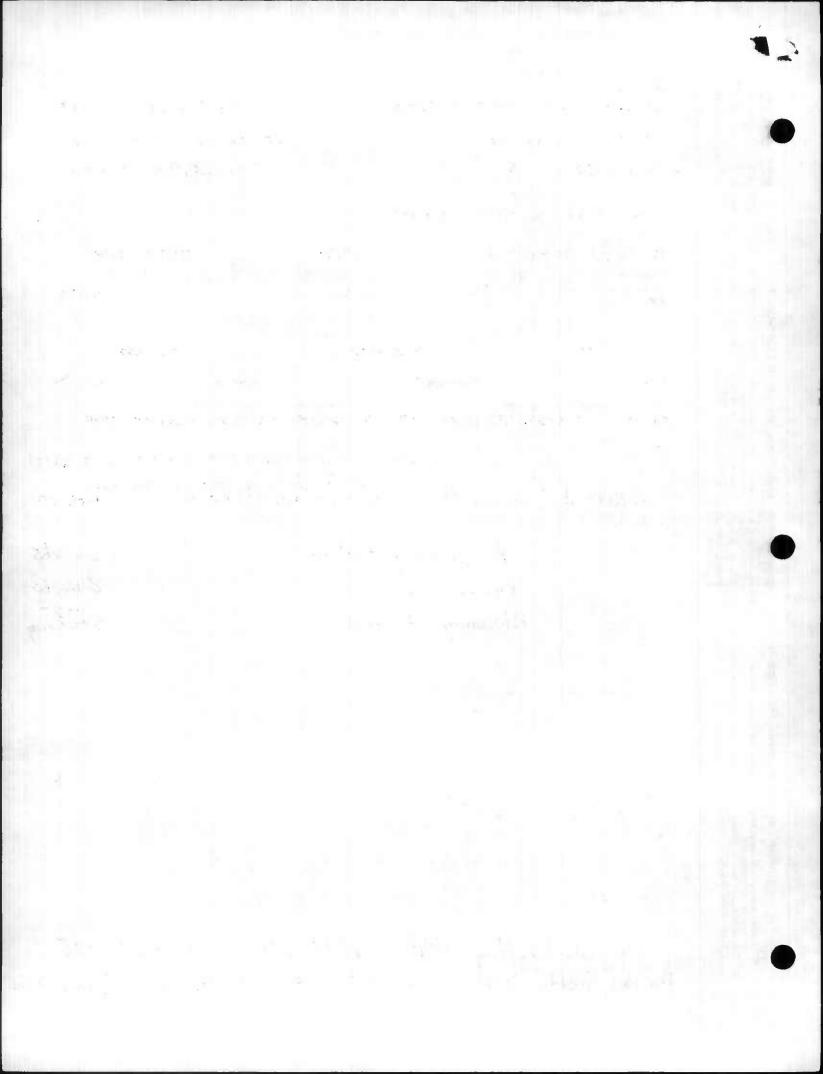
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d/cause of deeth (Item 23a) (Type, Print)

Medical Park Price Silver Spring 20902

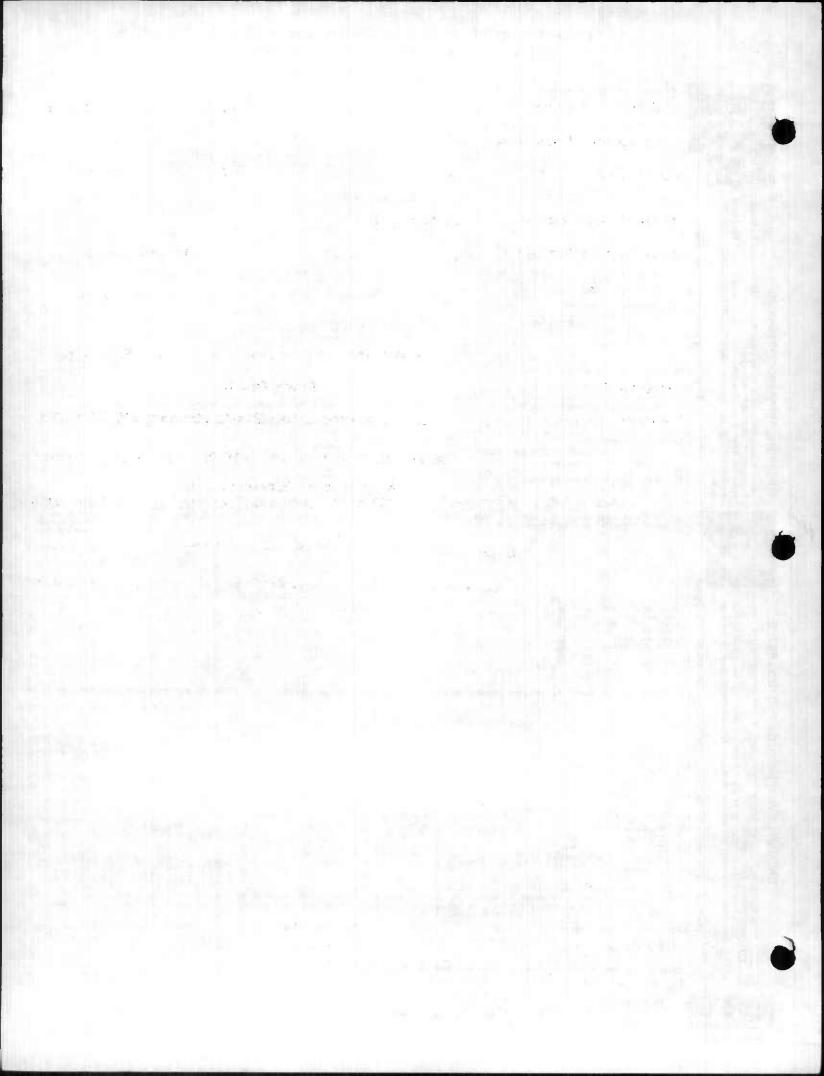
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State of Maryland / Department of	of Health and	Mental Hygier
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Physician
/Medical
Examiner

Funeral

Director

with the Marylend item 27 is marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Medical Examiner mast be notified at

Director

Funeral

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To Be Completed

pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a anath Injury or other traumatic event, the Medical Example Invest.

IMedical Examiner

Physician/Medical Examiner esn Completed by Be Certification: To

Baltimore, Maryland 21215-0020 **Physician** g physician end es the buriel-transit Division of Vital Records, P.O. Box 68760, the ettending physician signed by To the Hospital or Attending Physician: The law within 24 hours effer death.

To the Funeral Director: Affer this certificate hes is completely filled in by the funeral director, page 2.

HNER			Ce	niica	te or	Death			Reg	No.		1000		
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Ellen Rose Fo	hner							MAY		Dey 1998	Yeer	1756PM		
4e Facility Neme (If not institution		ımber)				4b. City, To	own, or Lo			4c. County	of Deeth	11/30111		
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114 EVANS STRE	6. Sex	7. Age (In yrs	last hirthday	If Unde	r 1 Year	ROCK If Under						COUNTY		
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Usual Residence of Decedent											-			
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											Oleto, Zi	p 0000)		
Timothy Patrick	c Fohner/	0.04	Diana of Dian	anition /Ala	ma al				Mar	yland_ oc. Location	211	14		
20a. Method of Disposition 1 □ Buriel 2 🕅 Cremetion	3 □Removel from		cemetery, cre	metory or	other pla	ce May	20.	1998	20	c. Location	City or 1	OWII, Siete		
4 Donetion 5 Other (S			ntgome						В	ethesd	la, M	aryland		
21. Signal of Funerel Service	Veru	√ M00	803 R	ockvi ockvi	lle,	Inc. Mary	30 1and	0 Wes	st Me 850-	ontgom 2805		neral Home/ Avenue		
23a. Pert1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea	ith. Do not er	nter the mo	de of dyi	ng, such es	s cardiec	or respiret	ory erres	t,		Approximete Interval Between Onset and Deeth		
Immediate Cause (Final		1							1		1			
disease or condition resulting in death)	e. Can	tact	gunsh	01 1	NOU	nol	to	nea	14					
		Due to (or es e conse	quence of):									
	b										i			
Sequentially list conditions,		Due to (or es e conse	quence of):						1			
if eny, leeding to Immediate cause. Enter Underlying											[
Ceuse (Disease or Injury thet Initieted events	С.	Due to (or es e conse	quenca of)	:						+			
resulting In death) Last											1	•		
	d								_					
								1						
Part II. Other efgniffcant condition	ona contributing to d	leath but not re	sulting in the	underlying	cause gi	ven in Part	I.	23b.	DIG tob	acco uae co	ntribute	to the cause of death?		

the cause of death? 1 ☐ Yee 2 1 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed? Limited 1 ☑Yes 2 ☐ No 24b. Were autopsy findings evallebte prior to completion of cause of deeth? 12 Yes 2 No

25. Was case referred to medical examiner?
1™ Yes 2□ No 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ₹ Residence 6 ☐ Other (Specify) 27. Menner of Deeth

28b. Time of Injury 28e. Date of Injury (Month, Dey Year) 5-18-98 1750

28c. Injury et Work? 2.80 No 1 Yes 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred self-inflicted gunshot wound 281. Location (Street end Number City or Town, State) or Bural Route Number. Rochville,

Maryland

Home

1 ☐ Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☑ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifie

5 Pending investigation

6 Could not be determined

29c. License number O.C.M.E.

MAY 19, 1998

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Radentz

31. Dete filed (Month, Dey, Year)

MAY 2 1 1998

1 Naturel

2 Accident

3 Suicide

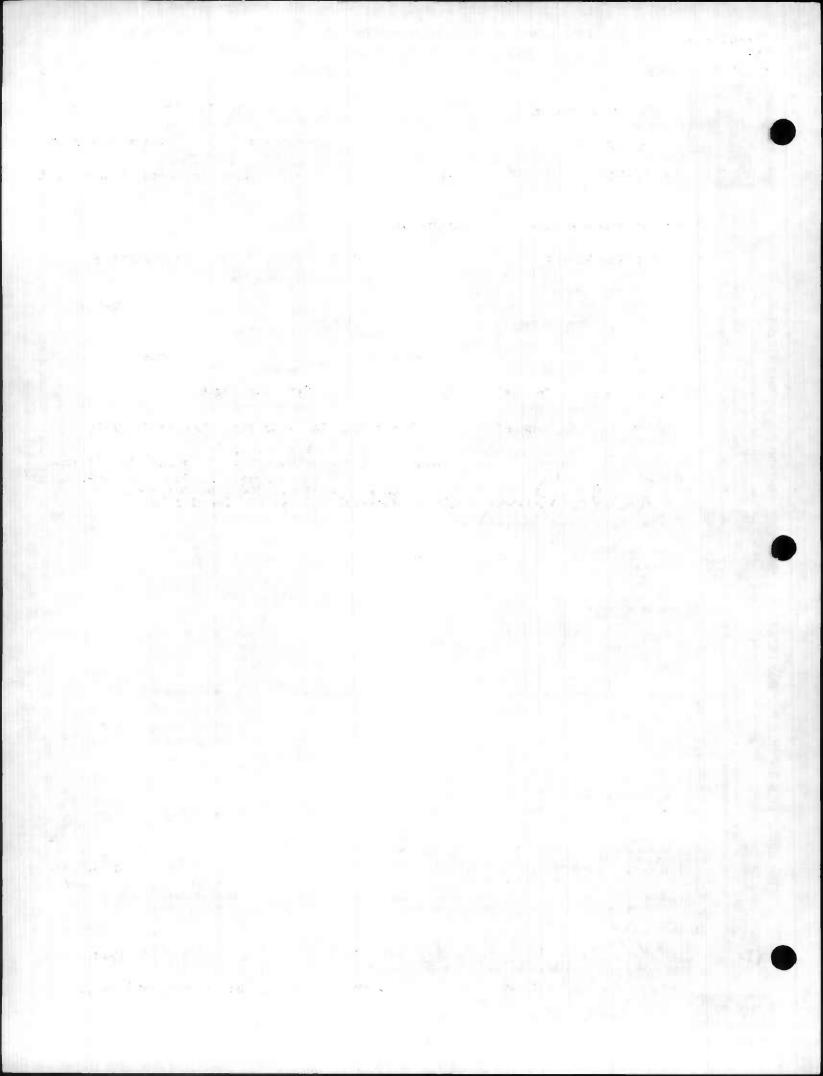
29e. Certifier (Check only one)

4 Homicide

111 Penn Street, Baltimore, Maryland 21201 32 Registrer's Signeture

State Registrar

Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth May 16, 1998 10:54 a.m. Johnson, Danie1 Fred 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthpleca (State or Foreign Country) 1943 Washington, D.C 5. Sociel Security Number 7. Age (In yrs. last birthdey) 11√ M 2□ F Months Yrs. 54 30, 577-58-9187 Usuel Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Mari; land Frederick Thurmont 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code United States 6509 Fish Hatchery Road 21788 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Meritel Status 1 ☐ Never Merried 2 Ø Merried 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electronic Technician Electronics 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Edwards Daniel Fred Johnson, Sr. Juanita 19a. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6509 Fish Hatchery Rd., Thurmont, MD Nona Eleanor Watts-Johnson 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) 5/20/98 New Windsor, MD Strawbridge UM Cemetery 22. Name end Address of Fecility Stauffer Funeral Homes. P.A. 21. Signature of Funerel Service Licanses 21702 1621 Opossumtown Pike, Frederick, MD 23a. Pert1. Enter the disease, or complications that caused the double on enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth . ACUTE ADATIC DISSECTION Immediate Ceuse (Finel diseese or condition resulting in deeth) UNKNOWN Due to (or es e consequence of): 23h. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were eutopsy findings evalleble prior to 24e. Wes an eutopsy performed? completion of cause of death?

Physician /Medicai Examiner

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

2

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Waddal Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Examiner physicien and the buriel-transit USB 88 1 signed by the e hes funeral director. After this

The lew requires that the deeth certificate be executed

or Attending Physician;

Hospital

24 hours efter death.

within 2 To the

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Certification: To

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

4 - Homlcide

Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 5 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a, Certifie

to Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. (Check only one) 29d. Dete signed (Month, Dey, Yeer)

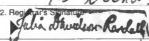
29c. License number 29b. Signeture end title of certifier uman

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 1CAMAN

TOLLHOUSE ANG # 307 FREDERICK MD 21701

State Registrar

edical



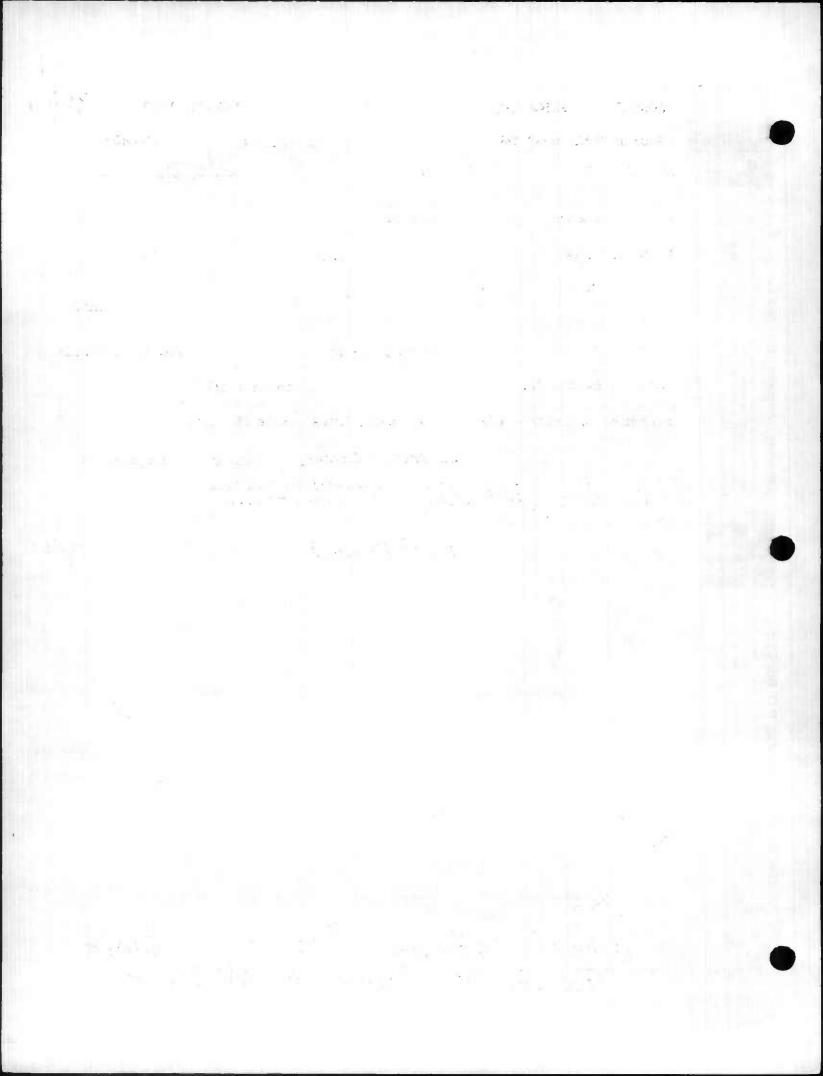
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death 47 **Physician** MAY 25, 1998 JOHN J FRICK III /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** SACRED HEART HOSPITAL ALLEGANY Cumberland 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. Dete of Birth (Month, Dey, Yee May 8, 1 Birthplece (Stete or Foreign Country)
 MD 7. Age (In vrs. lest birthday) **Funeral** MM 2DF Months Deys Hours 219-32-9176 62 Director Usuel Rasidence of Deceden the Marylenc 10c. City. Town or Location 10d. Inside City Limits 10e State 10b County 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at Yes 2□No MD Allegany LaVale Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code With 4 Forest Drive 21502 USA Funeral death Wes Decedent of Hispenic Origin? (Specify Yea or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11 Maritel Stetus 12. Wes Decedent Ever In U.S. Armed Forces?

1 Yes X No
If Yes, Give
Yeer or Detes: Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after of the of Health end Mentel Hygiena.
nt: if item 27 is marked other than "natural", or item 1 Never Merried 25 Merried 1 ☐ Yes X ☐ No Baltimore, Maryland 21215-0020 Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) Elemantary/Secondery (0-12) Coilege (1-4or 5+) Retired Buver Proctor & Gamble 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Nama (First, Middla, Last) John J. Frick, Jr. Kathryn (Bell) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Josephine E. Frick--wife 4 Forest Drive LaVale MD 21502 20b. Piaca of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 0 1 Burial 2 ☐ Cremetion 3 ☐ Ramovei from State Department o Important: If any Injury or Ambrose Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 05/28 Cresaptown MD 22. Name end Address of Fecility
Scarpelli Funeral Home 21. Signeture of Funeral Servica Licansee Cumberland, MD 21502 23e. Pert1. Enter the disease, or combinations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finei disease or condition resulting in deeth) Examiner Examiner that the death certificate be axecuted buriel-tran Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disaasa or injury that initiated avants resulting in daeth) Lest Dua to (or as a consequence of): and P.O. Box 68760. physician Physician/Medical the Due to (or es e consequance of) USB BS 23b. Did tobacco use contribute to the cause of deeth? the bed Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Probably 4 Unknown 2 1 ☐ Yes 2 ☐ No signed I Division of Vital Records, by 24b. Were autopsy findings eveilable prior to Completed 24e. Wes en eutopsy peen completion of cause of daeth? page 2 s 1 TYes 2 No certificate Hospital or Attending Physician: 24 hours after daeth. Funeral Director: After this certific director. 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only ona) Be Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 2 P/Outpetient 3□ DOA 2 No 2 1 Yes 1 Inpatient funeral 27 Manpar of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Naturel Accident investigation 1 Yes 2 No 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Roule Number, City or Town, State) 28e. Pieca of Injury - At home, farm, street, fectory, office building, atc. (Spacify) 4 Homicida To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To tha best of my knowladga, deeth occurred et the time, date end plece, and due to the cause(s) and menner as stated.

**Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and 30. Neme and eddre 31. Dete filed (Month, Day, Year)

State Registrar

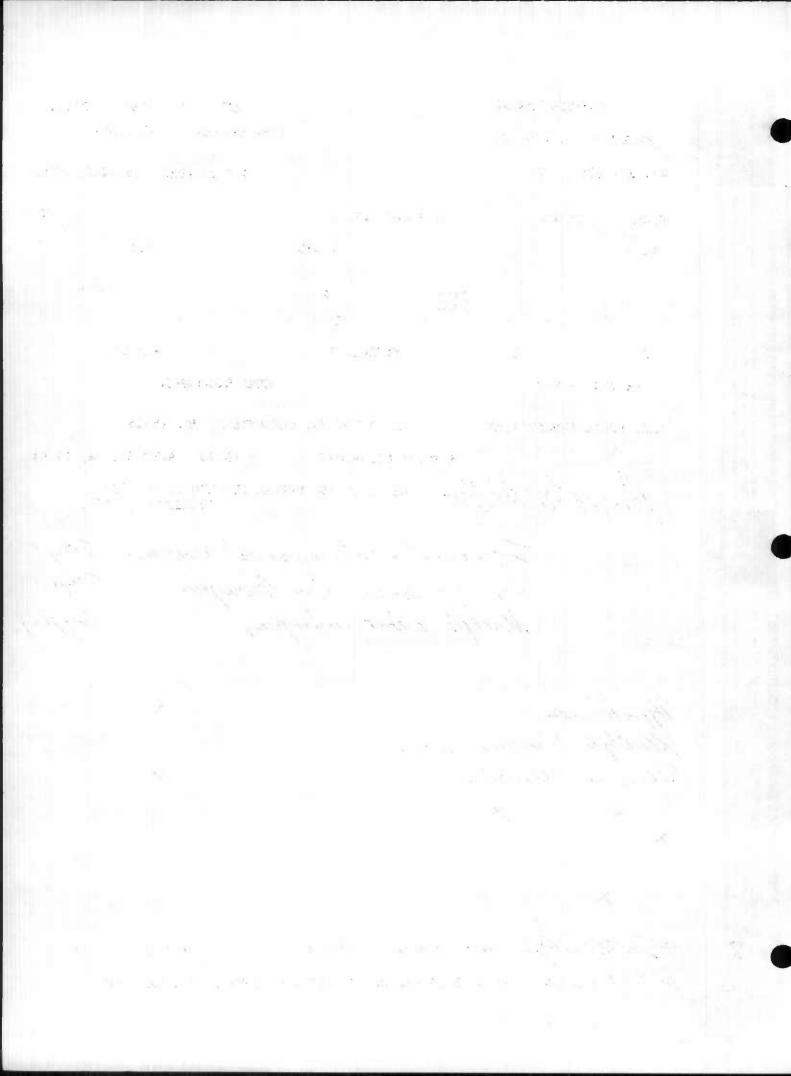
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		Reg. No.		1042
Dharista	1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	ath Day	Yaar	3. Time of Death
Physician /Medical	KENNETH	FENSKE					MAY	16 19	98	0245am
Examiner	4a Facility Name (If not institution, given SACRED HEART I				4	tb. City, Town, or L CUMB	ERLAND	4c. Count	y of Death LEGAN	ΥΥ
Funeral Director	407 22 0007	ex 7. Age (li	yrs. last bir	thday) If Und Months	er 1 Yaar Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da SEP 20	h y, Year) 1927	Cou	place (State or Foreigntry) COE, MINN
pu *	Usuai Residenca of Decedent 10a. Stata 10b. County	10	c. City, Town	n or Location						10d. Insida City Limits
vith the Maryl or 288-1 sho or notified a	PENNA BEDFOR	D	RD 2	CLEARVI	LLE					1 ☐ Yes ※ No
th with th	10e. Street and Number RD 2			10f. 2	ip Code 15	535		10g. Citizen of		intry?
Z 1 Z 1 D-UUZU d within 72 hours after death with the Manyland glene. glene "natural", or ferm 23a or 28a-f show the Modreal Examiner must be notified at completed by Funeral Director	11. Marital Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forcas? 1 X Yas 2 □ No If Yes, Give Year or Datas:	43-		-	lispanic Origin? (Si an, Maxican, Puert Specify:	pecify Yes or No o Rican, etc.)	Speci	ack, White	can Indian, , atc. HITE
ed within 72 hours ygiene. or than "netural", t, the Modical Ex.	15. Dacedent's Ed (Specify only highest gra		16a.	Decedant's Us (Give kind of v	uai Occup	ation during most of world)	king	16b. Kind of I	3usiness/ir	ndustry
within ene.	Elementary/Secondary (0-12)	College (1-4or 5+)				1)		AIRL	INEC	
	12 17. Father's Name (First, Middle, Last)	2		EXECU?	TAE	18. Mothar's Nan	ne (Firet Middle			
B gaby W	MARTIN FENSK						A STOEC		,,,,,	
should and Men marke armstic	19a. Informant's Name/Relationship (10h	Mailing Addre	ee (Street	and Number or Ru			State 7	in Code)
od 2 sho ith and 7 Is m traum			130							p 0000)
2 2 2 2	MRS . REMIE FENS 20a. Method of Disposition	KE/WIFE	20b. Placa of	Disposition (N	ame of	5, CLEARY	Date Date	20c. Location		own, State
Page int: If i	1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		y, crematory of	TORY		5-17-98	ALTO	ONA,	PA, 16601
permit. Departm Importar any Inju	21. Signature of Juneral Service Liour	WeValle	4	DALLA V	ALLE	ss of Facility FUNERAL	EVE	CRETT P		537
Physician /Medical Examiner	23a. Anti Entar Italiana. List only Immediate Cause (Final disease or condition resulting in death)	- 1		,	-	achnoria	0	,	4	Approximate Interval Between Onset and Death Sology S
death certificate be executed to attending physician and of or use as the burial-transit siclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that Initiated events resulting in death) Last	b. Kuptur c. Multiple d.	e to (or as a control of to (or a))).	Bally consequence of selfal consequence of	an	leng An	emysi T		<u> </u>	May year
at the death certified by the attending etached for use a Physician/M	Part II. Other significant conditions of	ontributing to death but n	ot rasulting in	n tha undariying	cause giv	ran in Part I.	23b. Did	tobacco uae c	ontributa	to the cause of deat
	"Afferten sion						1 🗆	Yes 2 No	3 Pro	obably 4 🗆 Unkno
been should	Multiple le	cura s	hou	5.			24a. Was	an autopsy rmed?	a	Vere autopsy findings vallable prior to ompletion of cause f death?
The lav	Server a	undele					10	Yes 2 No	1	☐ Yes 2☐ No
certificate rector, par	25. Was case referred to medical					26. Place of Dea	ith (Check only	one)	1	
	examiner? 1 Yes 2 No	Hospital:	2 ER/Ou	rtpatient 3□ (DOA Oth	er.	lome 5 Rasi		ther (Spec	ity)
Attending Physic daath. ector: After this by the funeral d	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		Time of njury M	28c. Injui Woo	yat rk? Yas 2 □ No	28d. Describe	how injury occi	urred	
2 0 2 4-	3 Sulcide 6 Could not by datarmined	28e. Placa of Injury building, etc. (S	At home, fa	ırm, straat, fact	ory, office		28f. Location (City or To		nber or Ru	ral Routa Number,
To the Hospital or A within 24 hours after To the Funeral Dire complately filled in D Medical Certi		ysician: To the best of mainer: On the basis of example manner stated	amination an							
Mithin To the comp	29b. Signature and title of confiller	21		2	9c. Licans	se number		29d. Data sign	ed (Month	, Day, Year)
∇	4/1/10	the MY	EAC	100	D136	01		MAY 16		1998
0	30. Name and address of person who	complated cause of death								
nes	U.R. FELID	9 40 2	SACR	ED HEAR	T HOS	SPITAL, C	UMBERLA	ND, MAR	YLANI)
	31. Date filed (Month, Day, Year)	32. Registrar's	Signature							

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:30 AM Joseph Conrad Felten 18 1998 MAY /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Yeer) Oct 25, 1 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months X M 2 F Days Yrs. MD 85 Director 214-07-6786 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Menyland Department of Health and Mental Hygiens. Important: If them 27 is marked other than "netural", or items 23s or 23s-f show say Inlury or other traumstic event, in Mesical Example mark be notified as any Inlury or other traumstic event, in Mesical Example 1 10c. City. Town or Location 10a. State 10b. County 10d. Insida City Limits X□ Yes 2□ No Directo Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1608 Holland Street 21502 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes X ☐ No If Yes, Give Year or Datas: 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) Black, White, etc. 1 Navar Marriad Married Baltimore, Maryland 21215-0020 1 ☐ Yes X☐ No Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) High School Retired Maintenance 12 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be Conrad Felten Johanna (Deatelhauser) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1608 Holland Street Cumberland MD 21502 Mary Felten-wife 20a. Method of Disposition 1 Mathod Disposition 1 Method of Disposition 1 Method of Disposition 1 Method of Disposition 1 Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) St. Patrick's Cemetery 05/21 Cumberland MD 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licensee Cumberland MD 21502 23a. Part1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner physician and s the bunel-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) ettending pl signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown þ law requires 24b. Wara autopsy findings available prior to should I Completed 24a. Was an autopsy performed? completion of cause of death? s cartificeta has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifice director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA funeral Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di Completely filled in

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) and manner stated.

29c. Licanse number

29d. Date signed (Month, Dey, Year)

-umberland MD 21502

State Registrar 29a, Certifier

(Check only one)

29b. Signature and title of cartifier

rad

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

321 Segistrar's Signature

Medicai

H. 17-5 Difference of the oranged sagerage To and 9 th, 1977 or an a 2 1787

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month Yaar 23, 15, 4c. County of Death Lena Drummond Gravenor /Medical 4b. City, Town, or Location of Daath 1:40 PM 4a. Facility Nema (If not institution, give streat and number) **Examiner** The Memorial Hospital 6. Sax 7. Aga (In yrs. last birthday) Easton If Under 24 Hrs. 8 Talbot If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) **Funerai** Days Hours 1□ M 2X F Yrs. Director 87 December 30, 1910 Virginia 219-05-9272 Usual Rasidanca of Dacedant the Maryland 10b. County 10a Stata 10c. City, Town or Location 10d. Insida City Limits show 7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Medical Examinar must be notified at 1 Yas 2 XNo Directo Maryland Caroline Denton 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 72 hours efter death with 26583 Shore Highway 21629 Funerai United States 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☐ Mo Specify: Š 3X Widowad 4 ☐ Divorced Specify: Caucasian Completed 16a. Dacedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry filed within 7 Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 8 Homemaker and Seamstress Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is merked othe any linyry or other traumatic event page. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Jacob Newton Drummond Rebecca Susan Litten 2 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Elaine Friel Daughter 26629 Shore Highway, Denton, Maryland 21629 Baltimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) Concord Cemetery 5/27/98 near Denton, Maryland 22. Nama and Addrass of Facility Moore Funeral Home, P.A. 1/10012 12 South Second Street, Denton, Maryland 21629 Part f. Entar tha disaasa, or complications that causad tha death. Do not antar tha mode of dying, such es cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. Approximata Intarval Batwean Onsat end Deeth **Physician** Immediate Ceusa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequantially list conditions, if any, leading to Immadiata causa. Enter Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by by 24b. Wara autopsy findings evallable prior to complation of causa of daath? leted 24a. Was an autopsy Compi certificate has 1 Yas 2 TH 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical Be 28. Placa of Death (Chack only ona) in 24 hours after death. the Funeral Director: After this ce Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient Other: 4 Nursing Homa 1 Yas 2 No 2 3E DOA 5 Rasidance 6 □Othar (Specify) 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Dascribe how injury occurred 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Box 68760. Division of Vital Records, P.O. or Attending Physician:

> State Registrar

edical

31. Date filed (Month, Day, Yaar)

30. Name and address of parson who comple

4 Homicida

29b. Signatura and titla of certifiar

29a. Certifiar (Check only one)

32. Ragistrar's Signatura reha way dson

and causa of death (Itam 23a) (Type, Print)

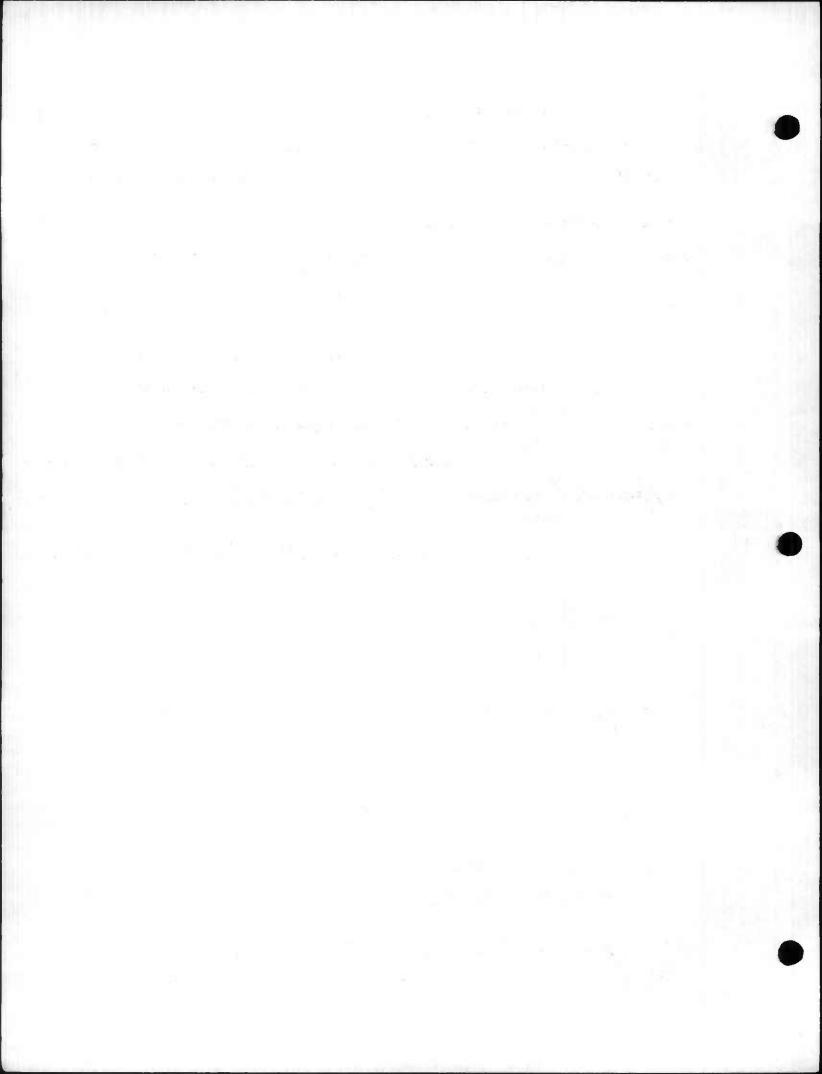
1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29c. Licansa number

29d. Data signed (Month, Day, Year

DHMH 16 Rev 6/95

within 2



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nema (First, Middla, Last) 2. Date of Daath 3. Time of Death **Physician** Reba Gebhardt. May 16, 1998 0145 /Medicai 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Magnolia Hall Nursing Hall Chestertown Kent. || Under 24 Hrs. | 8. Data of Birth (Month, Pay, Year) |
| June 23, 1899 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplece (Stata or Foraign 1□ M **XX**F 98 Maryland **Director** 214-16-4351 Usual Rasidance of Dacedant death with the Maryland 10b. County show 10c. City. Town or Location 10d. Insida City Limits id other than "naturel", or items 23s or 28s-f show event, tre Medical Examiner must be notified at Director Maryland XX Yas 2 No Kent Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 200 Morgnec Road Funeral 21620 United States 12. Wes Decedant Evar in U,S. Armad Forces? 11 Maritai Status Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Mexican, Puarto Ricen, etc.) Raca - Amaricen Indian, Biack, White, atc. Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "naturel", or ite 1 Naver Merried 2 Married ☐Yas 2☐No Yas, Giva Maryland 21215-0020 1 ☐ Yas 2 No Spacify: Completed by 3 Widowad 4 Divorcad Yaar or Dates: White 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Sacondary (0-12) Coliaga (1-4or 5+) Homemaker Domestic - Own Home 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nema (First, Middia, Maidan Sumama) Be James Downey Emma Urie other traumatic permit. Pages 1 and 2 shoul Department of Health and Milmportant: If item 27 is markeny injury or other traumations. 19e. informant's Neme/Ralationship (Type, Pnint) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mr. Robert Foreman - Son 107 Bayside Drive, Baltimore, Maryland 21222 Baltimore, 20b. Placa of Disposition (Nema of camatary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete X Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata Wesley Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) May 19, 1998 Rock Hall, Maryland 21. Signature of Funarai Sarvice Licensee Pellows, Helienbein & Newnam Funeral Home, P.A. William L. King Jr. M-00937 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset end Daath **Physician** /Medical Immadiata Causa (Final diseasa or condition rasulting in daath) a CONGESTIVE HEART FAILURE Examiner ATHERUSCEERUTIC CARDIOVASCULAR The law requires that the death certificate be executed Sequantially list conditions, if any, laeding to immadiate ceusa. Entar Underlying Ceusa (Diseasa or Injury thet initietad avants resulting in daath) Lest pue Box 68760. ettending physician for use es the buria Physician/Medical Due to (or es a consaquenca of): P.O. Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by No 3 Probably 4 Unknown 1 Yes ATTUAL FIBRILLATION Division of Vital Records, þ Completed 24b. Wera autopsy findings available prior to complation of cause of death? 24e. Was an autopsy performad? DLD AGE 1 ☐ Yas 2 No certificate Hospital or Attending Physician: Be 25. Was casa rafarred to medicel axaminar? 28. Pleca of Death (Check only ona) Other: Nursing Home P 1□ Yas 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Rasidance 6 Othar (Specify) After this 27. Magnar of Daath Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accidant invastigation efter death Director: / in by the 3 Suicida 6 Could not be detarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, ferm, straat, factory, office building, atc. (Specify) 4 Homicida within 24 hours eft To the Funeral DI completely filled in 29a. Cartifiar 12 Certifying Physician: To tha best of my knowladga, death occurred at tha time, dete end place, and due to the ceusa(s) and manner as steted.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at tha time, data and place, and due to the cause(s) and manner stated. edical (Check only one) To the 29b. Signature end titia of certifier 29c. License number 29d. Data signed (Month, Dey, Yaar) D41587 8 6 30. Name and address of person who completed causa of deeth (Item 23a) (Type, Print) Helen A. Noble 122 Speer Road, Chestertown, Maryland 21620

32. Registrar Signetur

State Registrar

31. Date filed (Month,

July Windows Holas

86 F F 188

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #20b, 5/22/98, BMW, Montg. Co. Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Data of Death 3. Time of Death Virginia L. Gilliam 17, May 1998 7:10 AM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street and number) Randolph Hills Nursing Home Wheaton Montgomery If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2₽9 F Months Deys Yrs. 227-16-0353 82 May 6, 1916 Virginia Usuel Residence of Dacedani 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Montgomery Maryland Rockville 10f. Zip Coda 10g. Citizan of What Country? 10e. Street end Number 20852 4613 Coachway Drive United States 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No Wes Decedant of Hispenic Origin? (Specify Yas or Nott Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14 Rece - American Indian 11. Maritel Status Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Dacedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry 16a. Dacedant's Usuai Occupation (Give kind of work dona during most of working life. DO NOT usa retired) College (1-4or 5+) Elementery/Secondery (0-12) Salesperson Department Store 10 17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maiden Sumame) Robert Parks, Sr. Addie Cornett 19a. Interment's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) William H. Gilliam/Son 4613 Coachway Drive, Rockville, Maryland 20852 20b. Place of Disposition (Nama of cematary, crametory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 □ Cramation 3 □ Ramovel from State Brentwood, Maryland Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 5-23-98 21. Signature of Funaral Sarvice Licensee

22. Name and Addrass of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Partt. Enter the disaasa, or complications that causad the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrest,

Approximate Intarvai Between Onsat and Deeth tmmediata Causa (Final disaasa or condition rasulting to daath) Chronic Renal Failure Years Dua to (or as a consaquance ot) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consaguance ot): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examine

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Directo

Funeral

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Completed

with the Maryland

death \

filed within 72 hours after

Hygiene.

h end Mental I should be

permit. Pages 1 and 2 sh Department of Health end Important: if hem 27 is in any injury or other traum 0058.

other

Baltimore, Maryland 21215-0020

attending physician and for use as the burial-transit 82 the

Box 68760,

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Division of Vital Records,

Hospital

To the I within 2

Examiner

Physician/Medical

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Certification:

edical

certificate be executed lew requires that the death signed by ti Deed certificate has The L Physician: After this funeral or Attending n 24 hours after death.

Funeral Director: Aft
bletchy filled in by the fur

25. Was case refarred to medical axaminar?

1 ☐ Yas 2 No

27. Mannar ot Deeth

1 Naturel

2 Accidant

4 Homleide

3 Sulcide

one)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary myocardopathy with biventricular

28a. Data of Injury (Month, Dey Year)

failure; Cellulitis; dementia

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify)

28b. Tima of

1 Yes 2 No 3 Probably 4 Unknown 24e. Was en autopsy performed? 1 ☐ Yas 2 No

24b. Wara autopsy findings eveileble prior to completion of cause of daath?

1 Yes 2 No

26. Placa of Deeth (Check only one) Other: 4X Nursing Homa 5 Rasidence 6 Other (Specify) 28d. Dascribe how Injury occurred

29e. Certifie (Check only

5 ☐ Pending

invastigation

6 Could not be detarmined

128 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifiar

29c. Licanse number D08944

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

29d. Deta signed (Month, Day, Year)

May 18, 1998

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

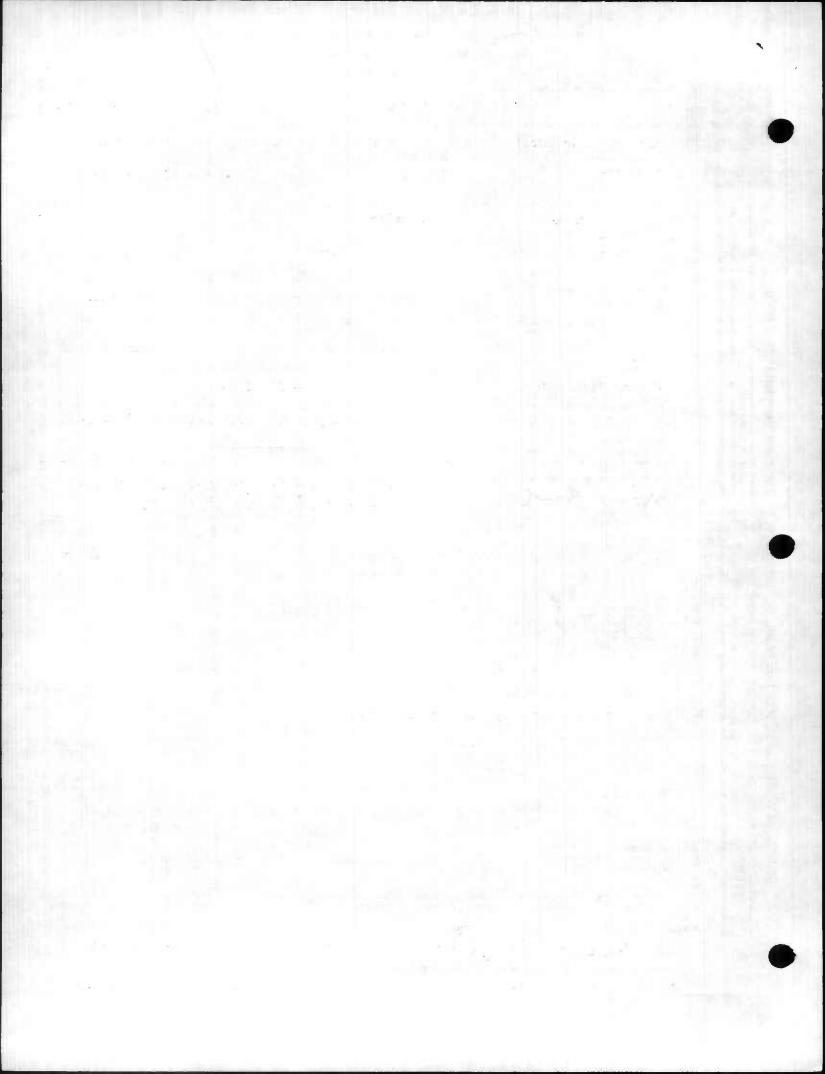
30. Nama and addrass of person who completed only of death (Item 23a) (Type, Print)

Hospital:

Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, Maryland

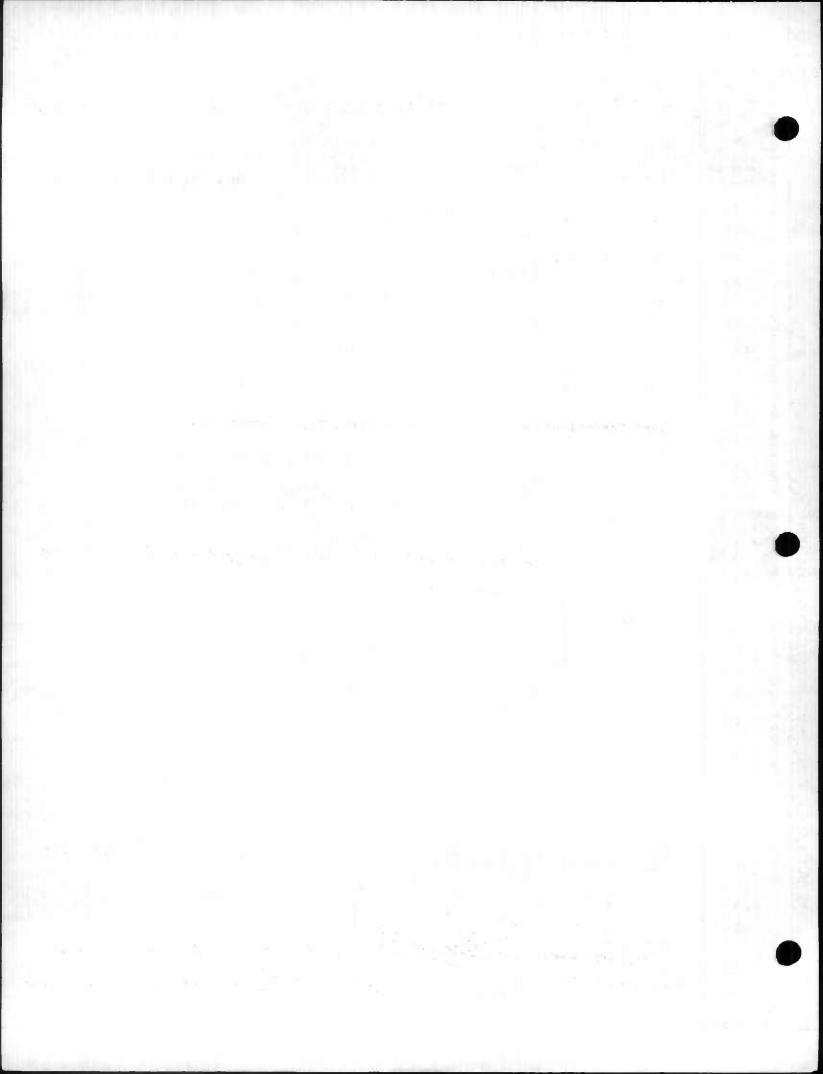
State Registrar 31. Data tiled (Month, Day, Year) MAY 1 9 1998





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \

				,	State o	f Mar			ment of ficate o				giene		7047
Physicia /Medica		1. Decedent's Name	(First, Middle	e, Last)					=/N			2. Dete of De		9 Year	3. Time of Death
Examine	-	4a. Facility Name (If Suburbar	Hospi	ital	reet end nu					4b. City, Bet	Town, or L hesda	ocation of Deati	MOn	t.	
Funeral Director		5. Social Security Nu 215-54-8 Usual Residence of	3693	6. Sex 1 ☐ N	M 2534F	7. Age (i	In yrs. lest birth		Onths Day		der 24 Hrs. Min.	(Month, De	th ly, Year) 5, 1906		place (State or Foreign intry)
death with the Maryland ms 23s or 28s-1 show rms the notified st	tor	10a. State Md.	10b. County			1	Oc. City, Town Bethe		on						10d. fnside City Limits 1 ☐ Yes 3€☐ No
or 28a	Director	10e. Street end Num	ber						10f. Zip Code)			10g. Citizen of	Whet Cou	intry?
ē 22	by Funeral	4949 A] 11. Marital Stetus 1 Never Marrie 3 XWidowed	ed 2□ Mam	12 rled	2. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	rces? 20 No	er in U,S.		2081 Decedent of s, specify Cu	f Hispanic uban, Mexi		ecify Yes or No Rican, etc.)	USA 14. Ra Bla Specia	ck, White	ican Indien, , etc. hite
5-0 72 hc	Completed to		15. Deceden	t's Educa	itlon			Give kind life. DO	's Usual Occ d of work don NOT use reti	upation ne during m ired)	nost of work	ing	16b. Kind of E	Business/ir	
Baltimore, Maryland 2121. permit. Peges 1 and 2 should be filed within Department of Health and Mental hygiene. Important: if Item 27 is marked other than "any injury or other traumatic event, the Messons.	To Be C	17. Father's Name (I	First, Middle, Seal				,			18. Mc	other's Nam Jen		Meiden Sumei uter	me)	
Mary and 2 shor alth and A 27 le me		19a. Informent's Nat Edward Ga							Address (Stre				er, City or Town 20816		ip Code)
imore Peges 1 is Tent of He int: If Item		20a. Method of Disposition 1 Buriel 2 □ 4 □ Donation	osition Cremation	3 □Rer			20b. Place of I cemetery	Disposition, cremeto		lece)	y 5/1	Dete 8/98	20c. Location		own, State
Balti Bemit. Departir Importa any inju		21. Signature of Fun	neral Servica	Licanse				Edwa	ame and Add	gel F	unera	T	ction	20	952
Physician		23a. Pert1. Enter the shock, or hear	e disease, or t failure. List					ot enter ti	he mode of d	lying, such	as cardiac	or respiratory a	rrest,	1	Approximate Interval Between Onset end Death
/Medical Examiner	Jer	Immediate Cause (F disease or condition resulting in death)		a. !		Du	ie to (or as a co			HE	mm	ORH	A GE		ACUTE
STE) OX 6876(certificate be nding physicial use as the bun	an/Medical Examiner	Sequentially list con if any, leading to Imcause. Enter Under Ceuse (Disease or is that initiated events resulting in death) L.		c		Du	e to (or as a co								
P.O. Bothat the death ed by the etter deteched for u	Physician/Me	Part ff. Other signiffe	cant conditio	ons contri	ibuting to de	eath but r	not resulting In	the unde	dying cause	given in Pa	art i.				to the cause of death?
BCMs, ecords, aw requires the second signer 2 should be detailed.	Completed by F											24a. Was	an autopsy omed?	9	Vere autopsy findings vallable prior to completion of cause of death?
Vital Recolling the law certificate has rector, page 2	0	25. Was case reterre	ed to medical							ae Di	lose of Deel	1 □		1	☐ Yes 2☐ No
of Vita Of Vita Physician: this certific	ToB	examiner?				npatient		patient	3 DOA	Wher:			dence 6 □Ot	her (Spec	ily)
Division or Attending effer death. Director: Affer lin by the fune	Certification:	27. Manner of Deeth 1 Naturel 2 Accident 3 Suicide 4 Homicide	5 Pendin investig 6 Could r determ	gation not be	28a. Dete (Mont	1 16	28b. Ti fnj - At home, farr (Specify)	A		☐ Yes 2	No	FELL	N B Street end Num wn, Stete)	EDA	200 M rel Route Number,
Di Di To the Hospital or within 24 hours effe completely filled in	edical					asis of ex	aminetion end						ceuse(s) end m date end piece		
To the Ho within 24 To the Fu complete	Me	29b. Signature end t	itle of bertilion		0	11	in s	d	29c. Lice	onse numb	099	4	29d. Dete sign		, Dey, Yeer)
Stat Registra	6	30. Name and addre	JS C	who com	MAY	15	(Item 23e) (T / O L L Signeture Advan-Ra	F.5.	ev u		Ri				120847



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 048 Item: 5 per F.H. G-760 6/12/98 reb Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month GRABIN 6:25 PM **Physician** ESTHER /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year Months Deys if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 578-56-8261 Funeral 1□M 2 F Hours 10.03.1920 Director POLAND Usuel Residence of Decedent should be filed within 72 hours after death with the Maryland of Mantal Hygiene.

marked other than "natural", or ffems 23s or 28s-f ahow 10c. City, Town or Location 10d. inside City Limits 10a. Stete 10b. County r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 N No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 118 MONROE STREET APT. #604 20850 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: à 3X Widowed 4 □ Divorced WHITE Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 CASHIER RETAIL 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) th and Mental It is marked out Pages 1 and 2 should be MENACHEM MAHNES YOCHEVET (UNOBTAINABLE) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 s.
Department of Health ar important: if item 27 is s any injury or other trausonce. JOSEPH NISSEN SNYDER/SIL 12820 LAMP POST LANE, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State MT. LEBANON CEMETERY 5/20/98 ADELPHI, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Ligans 22 Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20853 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. pproximate sterval Between Inset and Death **Physician** /Medical Immediate Ceuse (Finet diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed physician and the buriat-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of) 88 ed by the a Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobecco use contributa to the cause of death? signed by t 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed peen page 1 Tyes 2 No 1 ☐ Yes certificata or Attending Physician: director Be 25. Wes case referred to medicat exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpetient 3 DOA this After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Neturei in 24 hours after the Europe After A 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end menner steted. 29a. Certifier edical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 0

4

State Registrar 31. Dete filed (Month, Dey, Yeer)

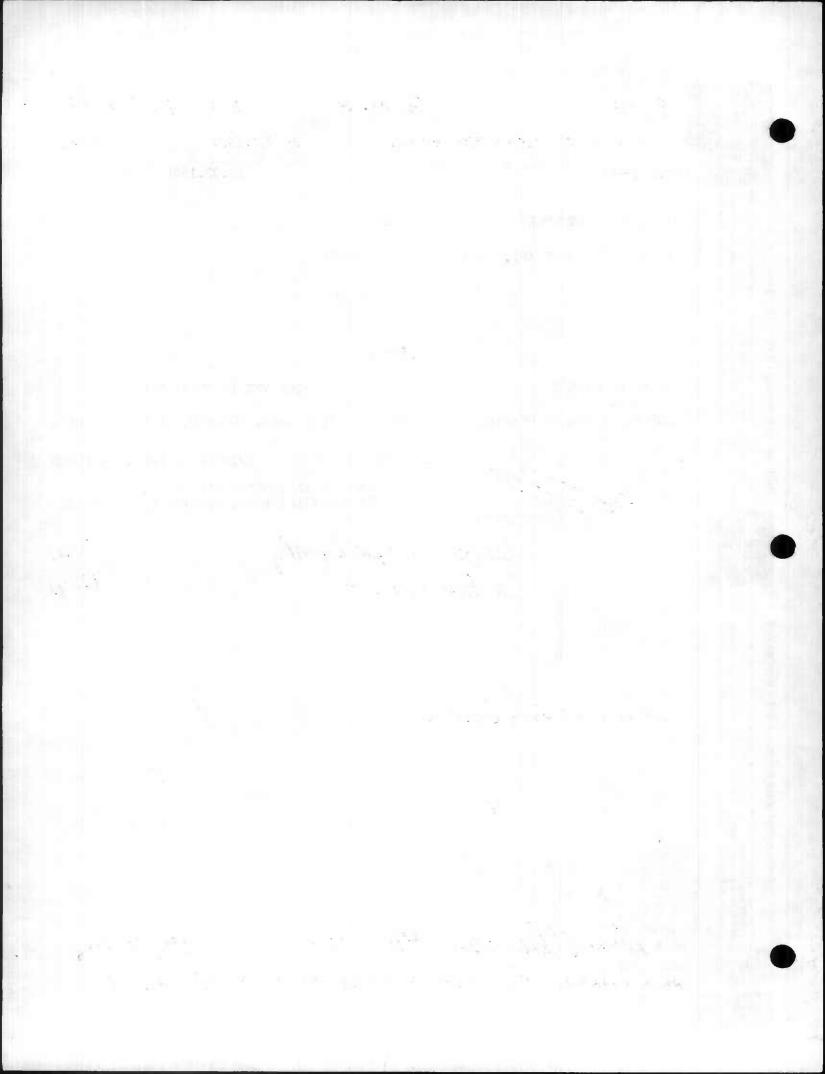
CHANACES



GROVE RD ROCKVILLE MO 20850

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95



Please

PM

Pleas	State of Maryland / [k Indelible ink. Assure A Department of Health and I		1 1	1 -	7049	
		Certificate of Death	Reg	g. No.			
ecedent's Neme (First, Middle	, Last)		2. Dete of Deeth Month	Dev	Year	3. Time of	Death
SAMUEL	GREENFIELD		MAY 17,	1998		6:00	PM
Facility Neme (If not institution	give street and number)	4b. Cîty, Town, or L	ocation of Death	4c. Count	ty of Death		
POTOMAC VALLEY	NURSING & WELLNES	S POTOMAC		MONT	GOMER	Y	

Funeral

Physician

/Medical

Examiner

1. Decedent's Neme (First, Middle, La

4e Facility Neme (If not institution, giv

Director with the Meryland 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Modical Examiner mast be notified at

Physician /Medical

Examiner requires that the death certificate be executed os the burial-tran Division of Vital Records, P.O. Box 68760, attending use for signed by the a been sig The law has certificate has lirector, page 2 Hospital or Attending Physician: director, this funeral After Director: To the Hospital within 24 hours a To the Funeral Completely filled edical

If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) AUG. 15, 1 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 1₽M 2□ F Months Deys Hours Min. 1914 CZECHOSLAVAKIA 83 Yrs. AUG. 077-24-7924 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND MONTOGMERY ROCKVILLE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1235 POTOMAC VALLEY ROAD 20852 UNITED STATES Funeral 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry MANUFACTURED Elementery/Secondery (0-12) College (1-4or 5+) SELF EMPLOYED WEDDING ALBUMS 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be CERIL KALKSTEIN GEDOLYAH GREENFIELD 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) (SON-IN-LAW) 7011 OLD CABIN LANE - ROCKVILLE, MARYLAND 20852 BURT ABRAMOWITZ 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) NEW MONTEFIORE CEMETERY 5/19/98 LONG ISLAND, NEW YORK at Funeral Service Ligensee 22. Name end Address of Facility
EDWARD SAGEL FUNERAL DIRECTION 1091 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart hallum, list only one cause on each line. Approximate Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting In deeth) 6 MONTHS CANCER - PANCREAS Due to (or es e consequence of): Physician/Medical Examine Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Disease or injury Due to (or es e consequence of): thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SENILE DEMENTIA (ALZHEIMERS) by 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNeturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D07471

29d. Date signed (Month, Day, Year)

MAY 18, 1998

State Registrar

PAUL T. NOONE, MD 31. Dete filed (Month, Day, Year) MAY 2 1 1998

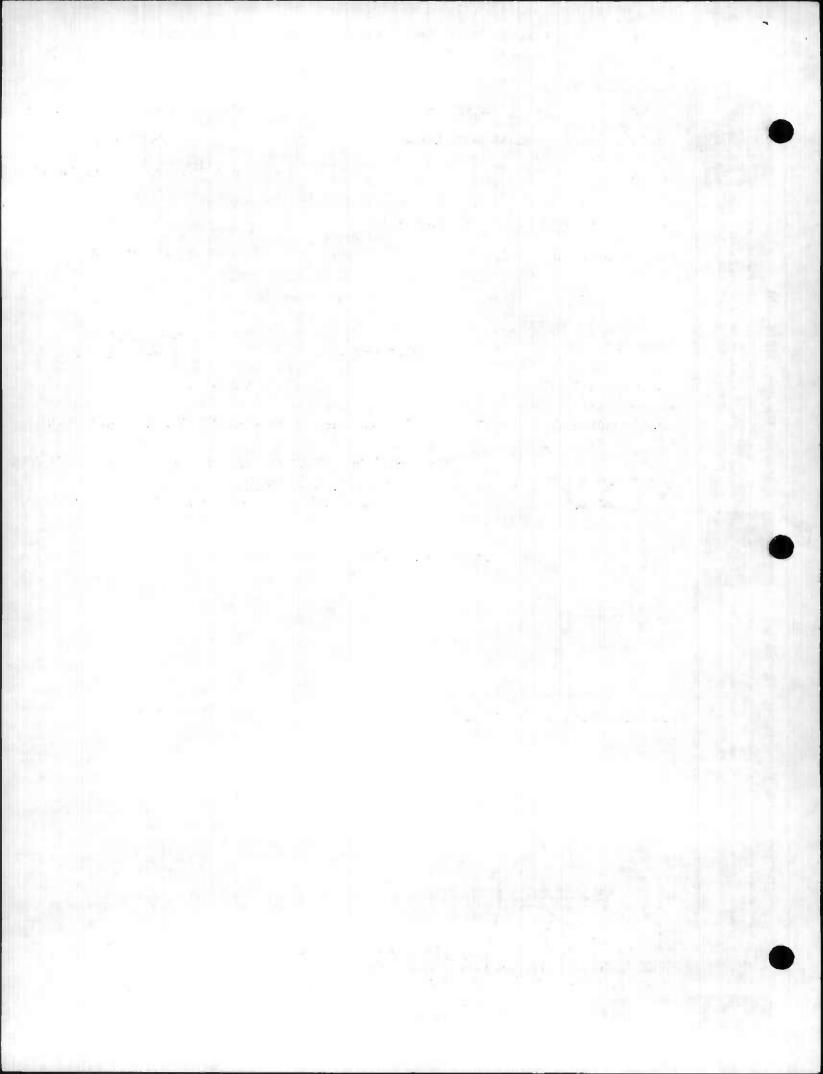
29b. Signature end title of certifier

30. Name and eddress of person who

29a. Certifier

50 W. EDMONSTON DRIVE - ROCKVILLE, MARYLAND 20852 32. Registrer's Signeture we Davidson gandell.

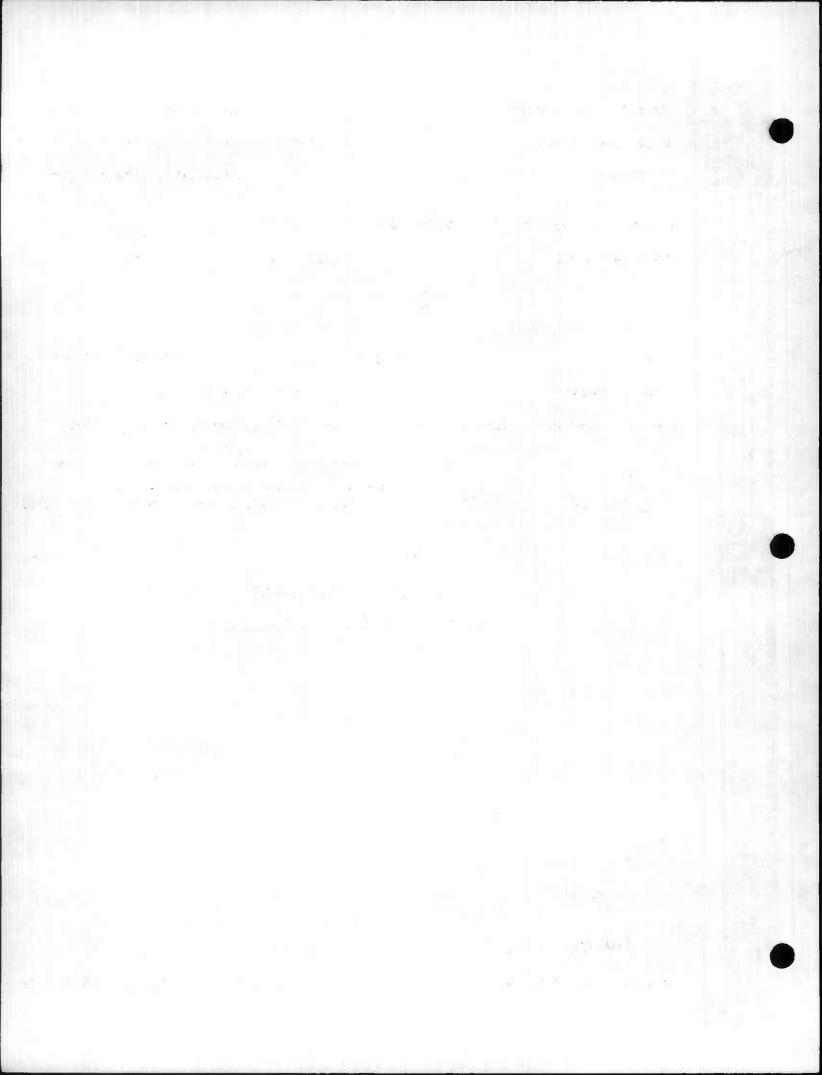
completed cause of death (Item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

		C	ertifica	te of	Death	F	Reg. No.	3 1/	050
Decedent'e Neme (First, Middle, La	ist)					2. Dete of Dea Month	ath Dey	Year 3. T	ime of Death
edical Edward Joseph Gu	ushen					May 14,		1	0:30 PM
4a Fecility Neme (If not institution, give	ve street end number)				4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth	
Holy Cross Hosp:	ital			5	Silver Sp			gomery	
5. Sociel Security Number 6. S		(In yrs. lest birtho	(ey) If Und Months	or 1 Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day	h v. Year)	9. Birthpiece (Stete or Foreign
tor 194-12-5457 Usuel Residence of Decedent	1 🕱 M 2 🗆 F	75 Yrs	b.			Sep. 25,	1922	Pennsyl	
10e. Stele 10b. County Maryland Montgor 10e. Street end Number 904 Kerwin Road 11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced		10c. City, Town o	r Location					10d. In:	side City Limits
Maryland Montgor	mery	Silver	Sprin	2				1(Yes 2₩ No
10e. Street end Number				ip Code			10g. Citizen of V	Whet Country?	
				2090)1		IJ	ISA	
904 Kerwin Road 11. Maritel Stetus 1 Never Merried 2 Married	12. Wes Decedent E Armed Forces?	ver in U,S.	3. Wes Dec		lispanic Origin? (Spen, Mexicen, Puert	pecify Yes or No-		e - American Inc	lian,
1 □ Never Merried 2 Married	1 X Yes 2 N If Yes, Give		1 ☐ Yes		Specify:	o riidan, etc.)	Specify	ck, White, etc.	
3 □ Widowed 4 □ Divorced	Year or Dates:	1962	10 165	280140	Specify.		Specify	White	
15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducetion	16e. De	ecedent's Us	uei Occup	oation during most of wor	kino	16b. Kind of Bu	usiness/Industry	
Elementary/Secondary (0-12)	College (1-4or 5	- In	e. DO NOT	use retire	d)				
5 12		Ar	alyst				Federal	Govern	ment
17. Fether's Neme (First, Middle, Last,	1)				18. Mother's Nan	ne (First, Middle,	Meiden Sumam	10)	
John F. Gushen					Mary A	gnes Yur	recek		
19e. Informent's Neme/Reletionship ((Type, Print)	19b. N	lailing Addre	ss (Street	end Number or Ru	ıral Route Numbe	er, City or Town,	State, Zip Code)
Louise E. Gushen	(wife)	904	Kerwi	n Roa	ad Silve	r Spring	. Marvl	and 209	01
20e. Method of Disposition		20b. Piece of D		ame of		Dete		City or Town, S	
1 ⊠ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif						5/20/98	1	X7.5	1-1-
21. Signatuo(of Funeral Service Long	-	Ariingi			al Cemete	ry #	Arlingto	on, virg	inia
6	Vacal	1	ranci	s J.	Collins	Funeral	Home, I	nc.	
Com s.	aewo		00_Un	ivers	sity Blvd	.,W.,Sil	Lver Spr	ing, MD	20903 oximete
23a. Party. Enter the disease, or com shock, or hear, fallure. List, mly	one ceuse on each lin	e.	Officer trie in	de or dyn	ng, such as caldiac	or respiratory ar	1031,	Inter	val Between
Immediete Ceuse (Final								1	or and Doorn
Immediate Ceuse (Final disease or condition resulting in death)	a	ST	ROK	=				1 1 1	week
		Due to (or es a cor	sequence o):					
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	b	Sei	Sune	oh	Sorder			i i	
Sequentially list conditions,		Due to (or es e cor	sequence of):					
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Ce	sonely	Asle	247	Sorder	ase			
Ceuse (Disease or Injury that initiated events resulting in deeth) Lest		hue to (or as a con	sequence of	U					
	d							i	
Pert II. Other significant conditions of	d								
Pert II. Other significant conditions of	contributing to death bu	t not resulting in th	e underlying	ceuse gi	ven in Pert I.	23b. Dld 1	tobacco use co	ntributa to the	suse of death
£						10	Yes 2□ No	3 Probably	42 Unknow
								Tan w	
<u> </u>							an eutopsy med?	aveilebie	topsy findings prior to ion of cause
do								of deeth	?
Pole						101	Yes 2 No	1 ☐ Yes	2 No
- Comple					26. Piece of Dec	eth (Check only o	ne)		
25. Wes case referred to medical							dence 6 DOth	er (Specify)	
25. Wes case referred to medical exeminer?	Hospitel:	nt 2 ER/Outpo	etient 3 [Otl	her: 4 Nursing H	lome 5 Resid	delice o moni		
25. Wes case referred to medical exeminer? 1 \(\text{Yes} \) 2 \(\text{No} \) No	28e. Dete of Injur	y 28b. Tim	e of	/UA	4 Li Nursing n		how Injury occur	red	
25. Wes cese referred to medical exeminer? 1 Yes 2 No	28e. Dete of Injur (Month, Day	y 28b. Tim	e of	28c. Inju Wo	4 Li Nursing n			red	
25. Wes cese referred to medical exeminer? 1 \(\text{Yes} \) Yes \(2 \text{No} \) No	28e. Dete of Injur (Month, Day	Year) 28b. Tim Inju	e of ry M	28c. Inju Wo 1	ry at rk?	28d. Describe f	how Injury occur		te Number,
25. Wes cese referred to medical exeminer? 1 \(\text{Yes} \) Yes \(2 \text{No} \) No	28e. Dete of Injur (Month, Day	Year) 28b. Tim Inju	e of ry M	28c. Inju Wo 1	ry at rk?	28d. Describe f	how Injury occur		te Number,
25. Wes cess referred to medical exeminer? 1	28e. Dete of Injur (Month, Day building, etc.	y Year) 28b. Tim Inju ry - At home, farm (Specify)	M M, street, fector	28c. Inju Wo 1 □	ry at rk? I Yes 2 □ No	28d. Describe to 28f. Location (Society or Town), and due to the	Street and Numb wn, Stete)	ber or Rural Rou	
25. Wes cese referred to medical exeminer? 1 Yes No 27. Menner of Deeth Netural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 2 Medical Example 1	28e. Plece of Injure 28e. Plec	y Year) 28b. Tim Inju ry - At home, farm. (Specify) I my knowledge, dexemination and/o	M M, street, fector	28c. Inju Wo 1 □	ry at rk? I Yes 2 □ No	28d. Describe to 28f. Location (\$ City or Tov.), and due to the time,	how Injury occur Street and Numb wn, Stete) cause(s) and ma dete end place,	ber or Rural Rou anner as stated, and due to the o	euse(s)
25. Wes cese referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signeture end title of certifier	28e. Dete of Injur (Month, Day be 28e. Plece of Injur (Month, Day building, etc.) 28e. Plece of Injur (Month, Day building, etc.) 28e. Plece of Injur (Month, Day building, etc.)	y Year) 28b. Tim Inju ry - At home, farm. (Specify) I my knowledge, dexemination and/o	e of ry M , street, fector eath occurrer investigation	28c. Inju Wo 1 : ory, office	ry at rk? I Yes 2 □ No	28d. Describe to 28f. Location (\$\frac{City}{City}\$ or Town, and due to the time,	how Injury occur Street and Numb wn, Stete) cause(s) and ma dete end place, 29d. Dete signe	enner as stated. and due to the o	euse(s)
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25. Wes case referred to medical exeminer? 1	28e. Dete of Injur (Month, Day be 28e. Plece of Injur building, etc. and manner sta	y Year) 28b. Tim Injury - At home, farm (Specify) I my knowledge, dexemination and/o	M M M M M M M M M M M M M M M M M M M	28c. Inju Wo 1 Dry, office d at the til in, In my office Dry, Chicent	ny at rk? I Yes 2 No me, date and plece ppinion, deeth occur se number	28d. Describe to 28f. Location (\$\frac{City}{City}\$ or Tov.), and due to the time,	Street and Number, Stete) cause(s) and middle end place, 29d. Dete signe	enner as stated. and due to the cod (Month, Dey,	euse(s)
25. Wes cese referred to medical exeminer? 1	28e. Dete of Injur (Month, Day be 28e. Plece of Injur building, etc. 28e. Plece of Injurbuilding, etc. 28	y Year) 28b. Tim Inju rry - At home, farm (Specify) I my knowiedge, dexemination and/or led.	M M M M M M M M M M M M M M M M M M M	28c. Inju Wo 1 Dry, office d at the til in, In my office Dry, Chicent	ry at rk? I Yes 2 □ No me, date and plece ppinion, deeth occur	28d. Describe to 28f. Location (\$\frac{City}{City}\$ or Tov.), and due to the time,	Street and Number, Stete) cause(s) and middle end place, 29d. Dete signe	enner as stated. and due to the cod (Month, Dey,	euse(s)

DHMH 16 Rav 6/95



HOLDEN

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death

GOODHAND

if Under 1 Year

3. Tima of Death

9. Birthplaca (Stata or Foreign

10d. Insida City Limits

Interval Between Onset and Death

HOURS

Haurs

DAVS

24b. Were autopsy findings available prior to completion of causa of death?

1 Yes 2 No

1 Yas 2 XNo

MARYLAND

WHITE

5:35 PM

2. Data of Death

MAY

4b. City, Town, or Location of Death

EASTON

if Undar 24 Hrs.

Day 1998

4c. County of Death TALBOT

20

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

THE MEMORIAL HOSPITAL

NETTIE

5. Social Security Number

Funeral

Director

death with the Maryland ns 23a or 28a-f show Heme

GOODHAND, NETTIE

pernit. Peges 1 end 2 should be filed within 72 hours efter de Department of Health and Mertal Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic event, the Medical Examinant.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

The law requires that the death certificate be executed and the burial-tran Records, P.O. Box 68760. use as Š page 2 should be this certificate hes Division of Vital Attending Physician: the funeral After efter death. filled in by ò

8. Date of Birth (Month, Day, Year) JAN. 16, 1910 Days Months Hours 218-20-7356 88 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Funeral Director QUEEN ANNE'S STEVENSVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 OLD LOVE PT. ROAD 21666 IISA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Maritai Status Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN FOOD & HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANKLIN COLE NETTIE MAE BROWN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS M. HOLDEN / SON 1700 N. DUPONT, E304, DOVER, DE 19901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurlal 2 Cremation 3 Removal from State SPRING HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 5-23-98 EASTON, MD 21601 21. Signature of Funeral Service Licansee 22. Name and Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Physician/Medical Examiner RESPIRATORY DISTRESS SYNDROME ADULT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ETIOLOGY PNEUMONIA Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Bilateral mastectomies 1 Yes 2 No 3 Probably 4 Unknown ð Completed (remote 24a. Was an autopsy bx) 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Slonature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Yaar) Landt Sahmel and 5-21-98

REINHARDT SAHMEL, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601

32. Registraris Signature

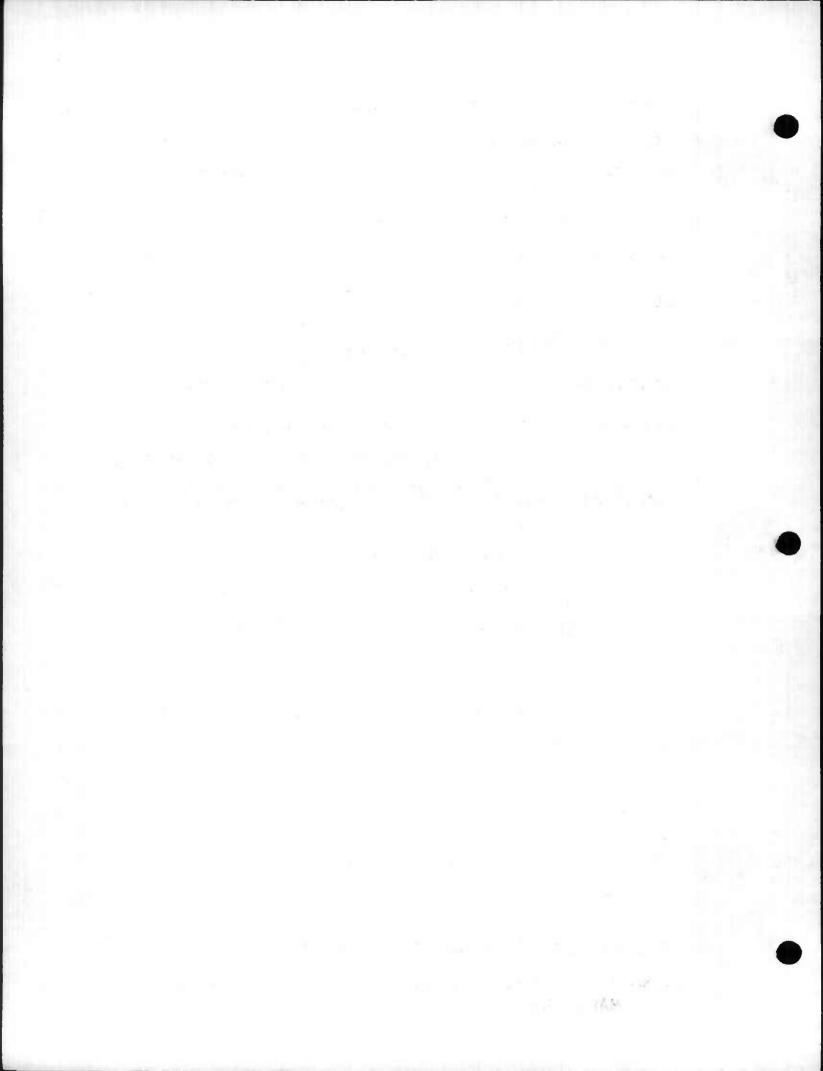
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

Hospitai 24 hours of Funeral I

To the within 2



98-2792-033 CMK HANK GRIFFIOEN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Funeral Director

Usuel Residence of Decedent with the Marylence 10a. Stete 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director MD PRINCE GEORGES BOWTE 10f. Zip Code 10e. Street and Number 3537 EMPEROR COURT 20716 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Aq. 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) DATABASE SPECIALIST other 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Ity Important: If itsm 27 le marked oth any Injury or other traumatic event DDBs. BERT GRIFFIOEN ILSE STACH 19e. tnforment's Neme/Reletionship (Type, Print) BERT GRIFFIOEN/ FATHER 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1XXBuriel 2 ☐ Cremation 3 ☐ Removel from Stete OXFORD CEMETERY 5-22-98 4 ☐ Donetion 5 ☐ Other (Specify) Funeral Septice License 22. Name end Address of Fecility ann Pent 1. Enter the disease, or comblications that sed the shock, or heart failure. List only one cause on each line Physician /Medical Immediate Cause (Final disease or condition resulting In death) Multiple Examiner Due to (or es e consequence ot): Examiner certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or trijury that initieted events resulting in deeth) Last physician end s the buriel-tran Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 28 esu Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 of Vital Records, by 8 Completed page 2 certificate hes Physician: 25. Wes case referred to medical Be 28. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1X Yes 2 No this 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: After 5 Pending Investigation 1 Neturel efter death. Director: Aft 5-17-98 1 Yes 2 PNo 1400 2 Accident 6 Could not be determined 3 SuicIde 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc., (Specify) 4 Homicide Hospital or Woods 4200 24 hours of Funeral 29a. Certifier edical (Check only one) within 2 To the the 29c. License number 29b. Signeture end title of certifier

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrary Signature

How L

1998 0

Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) HENDRICK GRIFFIOEN 1998 MAY 17. 1430PM 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) 4200 BLK. STEED ROAD-WOODED AREA CLINTON
If Under 24 Hrs. PRINCE GEORGES 6. Sex 1 M 2 □ F If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev, Year) Birthplece (State or Foreign Country) Months Deys Hours Min. Yrs. 218-58-0836 JULY 27, 1965 MARYLAND 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of Whet Country? USA 14. Race - American Indian. Black, White, etc. WHITE 16b. Kind of Business/Industry HUMAN RESOURCES 18. Mother's Neme (First, Middle, Meiden Sumeme) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 29407 STONEY RIDGE CIRCLE, EASTON, MD 21601 20c. Location - City or Town, Stete OXFORD, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 ed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 18 Yes 2 No 1 Stes 2 No Other: 4 Nursing Home 5 Residence 6 MOther (Specify) AT SCENE 28d. Describe how Injury occurred Pilot light WITCHAST Crash 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Stord BUK 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2M Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dey, Year)

O.C.M.E.

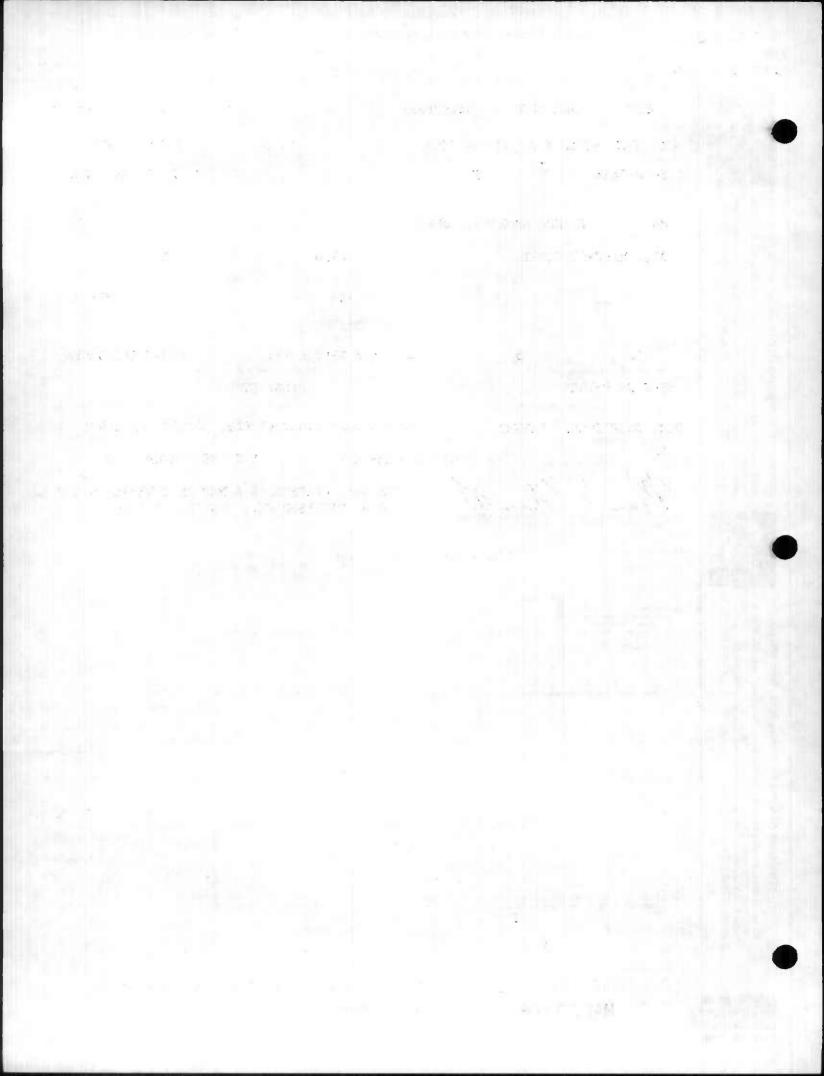
111 Penn Street, Baltimore, Maryland 21201

MAY 18, 1998

State Registrar

1. Javid

31. Date filed (Month



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Adrienne Clorette Guggenheim 16, May 1998 1:50 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick if Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Feb. 11, 1910 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 329-03-0913 88 Yrs. Illinois Director Usuat Residence of Decedent the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examinar must be notified at 1X Yea 2 □ No Director Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. 210 Magnolia Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American indian, Biack, White, etc. permit. Peges 1 and 2 should be filled within 72 hours after c Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exempted 2008. 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White by 3 Nidowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **SCHAEFER** FEIBER Corinne Cuthbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8289 Sugarman Drive, La Jolla, CA 92037 David M. Guggenheim, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory, May 18, 1998 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility MOO703 Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701 23e. Part 1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause or pach line. Approximate Intarvai Between **Physician** /Medical Myocardial Induction
Due to (or es e consequence of): immediate Cause (Fine) disaasa or condition resulting in death) Examine Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect deeth.

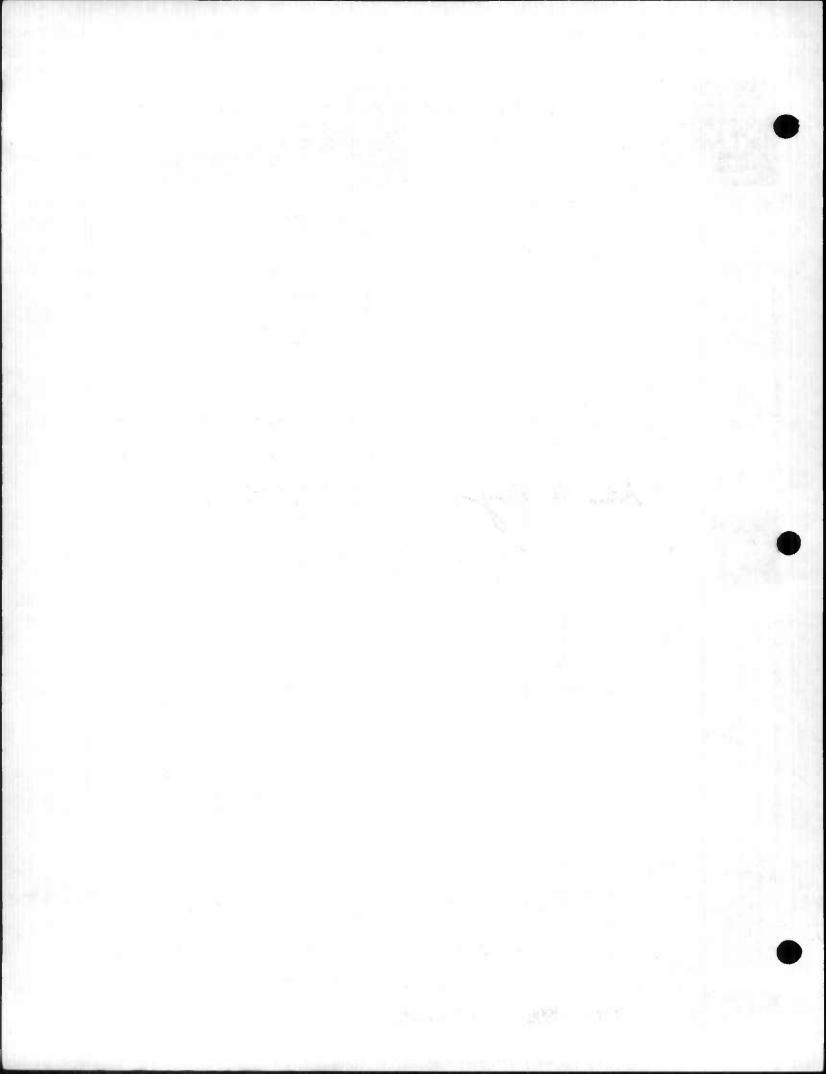
To the Fuheral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funneal director, page 2 should be deteched for use as the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, that initieted events rasulting in death) Last Due to (or es a consequence of): Part it. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient Certification: To 30 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. Medicai (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) my Pittowell ms 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Mary P. Howell, M.D., 915 Toll House Avenue, Frederick, MD 21701 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State

Julia Davidson Revolates

MAY 1 9 1998

Registrar

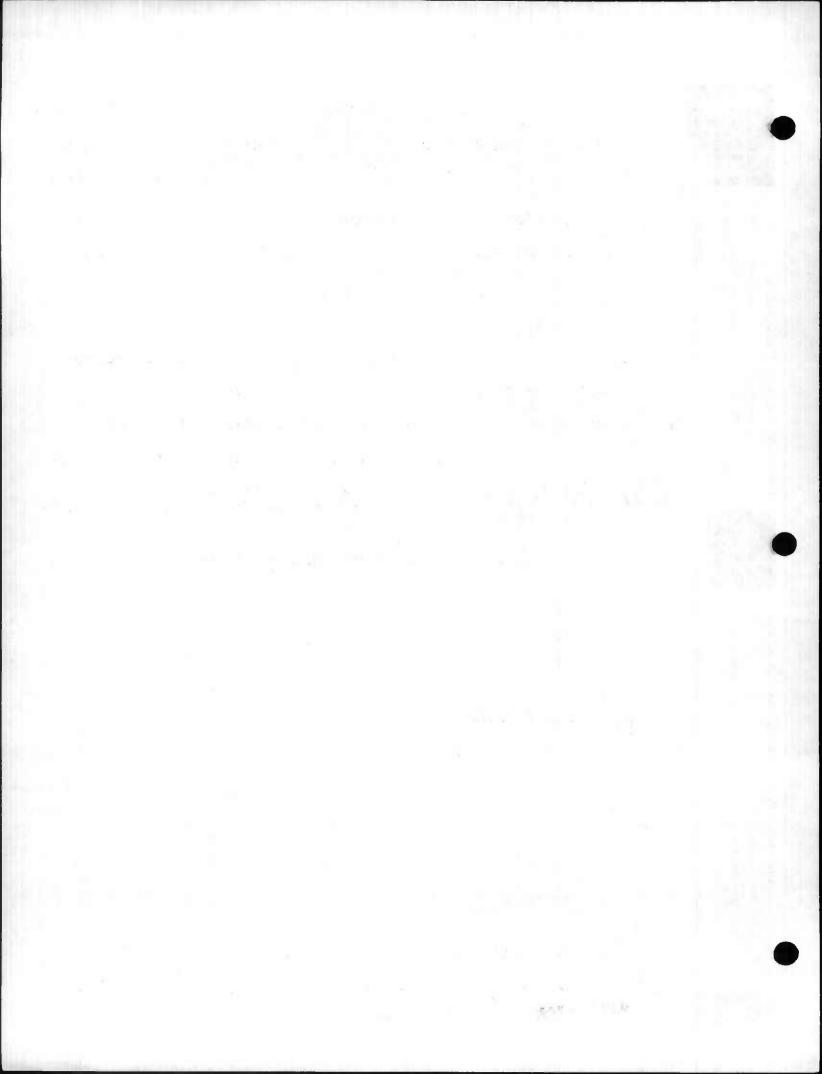


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 3. Time of Death 2. Date of Death Month **Physician** 12:55 AM Graham Velma May 11 1998 Grace /Medicai 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick
If Under 1 Yeer | If Under 24 Hrs. | 8, Date Frederick 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours Min. 1□ M 250 F Yrs. Director 217-12-1861 Aug. 26, 1924 Maryland Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1622 Shookstown Road 21702 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7: and Mental Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Secretery U. S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If flem 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Howard Walter Gerrick Grace Hartsock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Graham/Son 212 Diamond Drive, Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) May 14, 1998 Frederick, Maryland Mt. Olivet Cemetery 21. Signature of Funeral Service Licens 22. Name end Address of Fecility M00021 Keeney and Basford Funeral Home uacua 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line. 106 East Church Street, Frederick, MD 21701 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medicai . Chronic Obstructive Palmonay disease car. **Examiner** Due to (or es e consequence of): Examiner physicien and the burial-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 98 P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Whiknown heart tailure Division of Vital Records, þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was en autopsy Ceremany heart disease performed' The law 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 142 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: within 24 hours after death. To the Funerel Director: After 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medical 29a. Certifier 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. the th 29b. Signature and title of certifler 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) au, trelenck we 21702 Magistresis Signeture

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Registrar

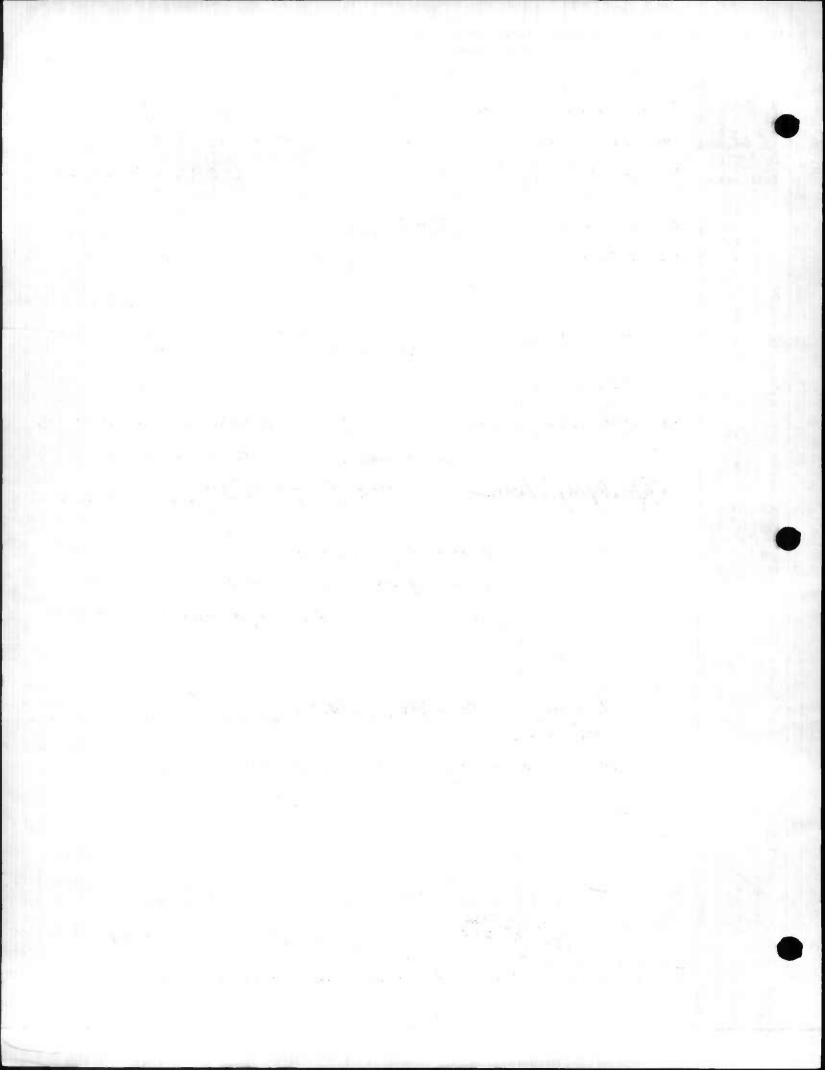
State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate of	Death			Reg. No.		
			1. Decedent's Name (First, Middle	a, Last)						2. Date of Dea	ath		3. Time of Death
	Physic		James Ormand	H	enrv					Month May	Day	1998	2:20 PM
	/Medi Exami		4a. Facility Name (If not institution					4b. City, To	wn, or Lo	ocation of Death		inty of Death	2.20 PM
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_	Funeral		5. Social Security Number	8. Sex	7. Aga (In yrs. Is		If Undar 1 Yaa			-			
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	_		Usuel Residence of Decedent							rater	10, 1	112 116	ilyland
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	N TE	ţ	Maryland Caro	lino	D	enton							1 ☐ Yes AF No
	128 P	Director	10e. Street and Number	LILE		SIICOII	10f. Zip Code				10g. Citizen	of What Cour	ntry?
7	3a o		85 Hobbs Road				2162	20				ed Stat	
	The 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S	3. 13.1	Was Decedent of		gin? (Sp	ecify Yes or No-		Race - Amaric	
	10.	F	1- Never Married 2 Marri	Armed Fo			f Yes, specify Cul	ban, Mexicar	, Puarto	Rican, etc.)		Black, White,	
7	e sur	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	ve **		1 ☐ Yes 21X No	Specify:			Spe	elly: Nucasia	an .
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5	an ar urial-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		horni		enica	Him!	VY	naha	MY		weeks
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Attending	death. ctor: A y the fu	cati	2 ☐ Accident investig	ation			M 1	Yes 2	No				
or Attending	re-d	ertification:	3 ☐ Suicide 6 ☐ Could not determine	ned 28e. Place	of Injury - At honing, etc. (Specify)	ne, farm, str	eet, factory, office			28f. Location (S City or Tow	treet and Nun, State)	ım <i>ber</i> or Rure	al Route Number,
נ ב	within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Ce											
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2	in 24 Plete		one)	xaminer: On the ba and mann	ner stated.	on and/or inv	estigation, in my	opinion, dee	in occurr	ed at the time, t	ate and plac	ce, and due to) ine cause(s)
5	To Co	Σ	29b. Signatura and title of certifier	NIST	43		29c. Licen	se number		1	29d. Date sig	gned (Month,	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 9

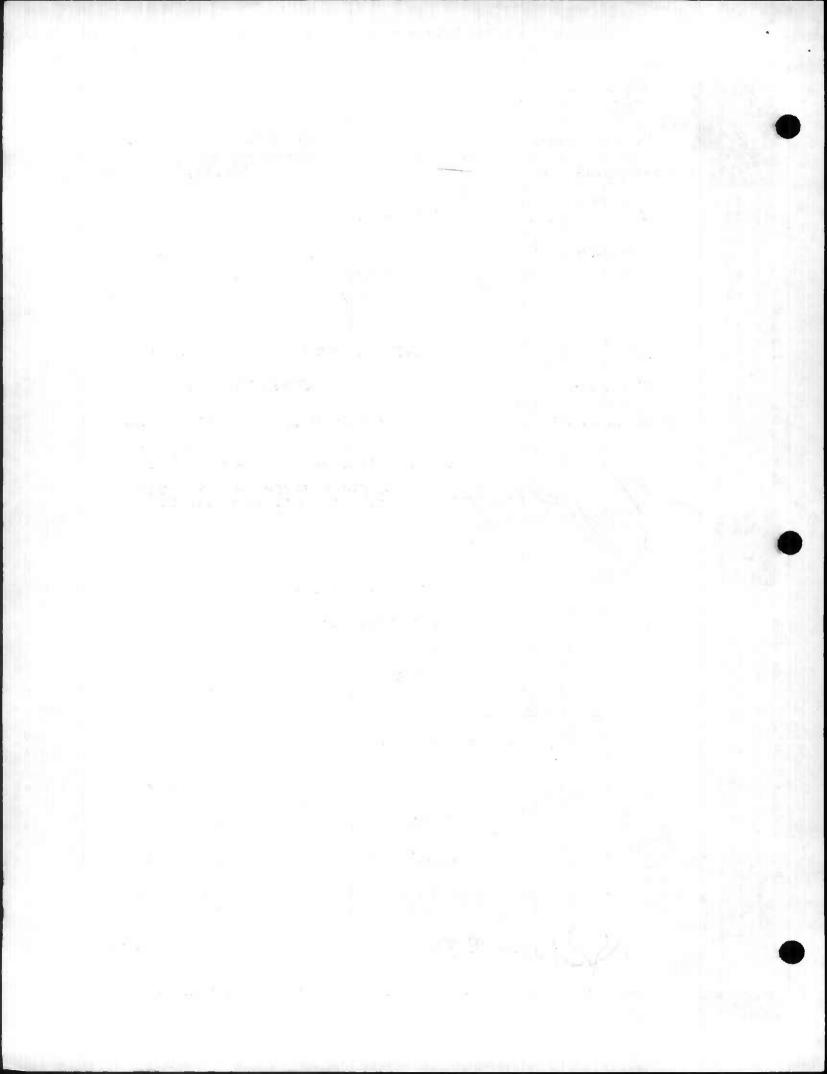
Amend #7,	5/21/9	8,BMW	,Montg.Co
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na	#/, 5/	21	/ 90, DAW, MOITEG.				Ce	rtificate	of	Death			Reg. No.		7000	
	Physic /Medi		1. Decedent's Name (First, M JOHN E		HONES				-,-			+	,1998	Year	3. Time of Death 4:45pm	
ii.	Exami	ner	4e. Facility Name (If not Instit			um <i>ber)</i>				4b. City, To		ocation of Deel LY		P.G.		
	Funeral Director		5. Social Security Number 225 – 05 – 300	,	Sex IXIM 2□ F	7. Age (In yrs. 86 -88		Months Months	Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Bi OCT . 3	0,1911	9. Birth Cou VII	place (State or Foreign Intry) RGINIA	
	the Maryland 28a-f ehow	tor	Usual Residence of Deceden 10a. State 10b. Cou	nty	.G.		y, Town or L APITO	ocation L HEI	GH'	TS					10d. Inside City Limits 1 No 2 No	
	h with the	al Director	10e. Street and Number 1218 BALI	BOA	AVENU	E		10f. Zip C	ode 07	43			10g. Citizen of USA		intry?	
020	filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or items 23a or 28s-f ehow int, the Medical Examinat multibe motified at	by Funeral	11. Marital Status 1 Never Married 2 1 3 Vidowed 4 Divor		12. Was Dec Armed F 1 Yes If Yes, G Yeer or I	cedent Ever in U, forcas? 2 No live Dates:	,S. 13.	Was Deceder If Yes, specify 1 ☐ Yes 25			gin? (Sp , Puerto	pecity Yes or No Rican, etc.)	Rican, etc.) Black, 1		- American Indien, , White, etc. BLACK	
2-01717	within 72 ho lena. than "naturi The Medical I	Be Completed	15. Dece (Specify only hi Elementary/Secondary (0-1 4 T H	thest gra	ide completed,	(1-4or 5+)	4or 5+) 16a. Dacedant's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) MACHINE OPERATOR				king	16b. Kind of I				
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Wica: y	Pages 1 and 2 ment of Health ant: if Item 27 I ury or other try		19a. Informant's Name/Relate BARBARA A.			aughter							er, City or Town			
Salumore, maryland 21215-0020			20a. Method of Disposition 1 Ruriai 2 □ Cremati 4 □ Donation 5 □ Othe			State	Placa of Disponental Communication of the Place of Disponental Communication of the Place of the Place of Disponental Communication of the Place of th	osition (Name matory or oth Y MEM	of er pla	ca)		Dete	LANDO	- City or T		
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	Physician /Medical Examiner		immediata Causa (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of):											Crisel and Deeth		
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	ras that signed t be det	by		ABE	TES ME	ELLITUS	•									
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		Be Co	25. Was case referred to med	ical			_			26 Place	of Dee	th (Check only	Yes 2□No	1	☐ Yes 2☐ No	
	ysicien: is certific director,	To B	examiner? 1 ☐ Yes 2X No		Hospital:	Inpatient 2X	ER/Outpetie	nt 3 DOA	Oth	or.			idence 8 🗆 O	her (Speci	ify)	
	Attending Physicien: r death. ector: After this certific. by the funeral director,	Certification:	2 1 100/00/11	stigation	1	of Injury onth, Day Year)	28b. Time o Injury	of 280	Moi	yat rk? Yes 2□	No	28d. Describe	how injury occu	irred		
5	ital or Attend its after death el Director: ,	Certific	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide det	ild not be	28e. Plac	a of Injury - At ho ling, etc. (Specif)	ome, farm, st	reet, factory, o	offica			28f. Location (City or To	(Street and Num wn, Stete)	ber or Rur	ral Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director Complataly filled in the funeral or the formula of the funeral or the funera	edicai	29a. Certifiar 1	ying Ph al Exam	niner: On tha b	a best of my kno- pasis of axaminal nner stated.	wledge, daat tion and/or In	h occurred at vastigation, in	tha tir	na, date an plnion, daa	d place, th occur	and due to the rred at tha tima,	cause(s) and n data and place	anner as , and dua	stated. to the causa(s)	
	vithin 2 To the compla	M	29b. Signature and title of cer	Q	wi	MID).			e number 213			29d. Date sign			
			30. Nama and address of Ann			se of death (Item			ח	#220	BO	WIE MD	20716			
			7701	-434	1000	LITT TOTTE		THE IT	U.	11 440	DU	17 III - 1711	. LU/10			

DHMH 16 Rev 6/95

Registrar

MAY 2 1 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First Middle Last) 2. Data of Death 3. Tima of Death Month Yaar SYLVIA S. HALPERT MAY 16, 1998 3:00 PM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) Days 1 M 20 F Yrs. 84 125-05-0016 FEB. 26,1914 NEW YORK Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No MONIGOMERY MD. BETHESDA 10e. Street and Number 10f. Zlp Coda 10g. Citizen of Whal Country? 4606 BAYARD BLVD. 20816 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 💥 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 X Married 1 Yas 2 No Specify: Specify: 3 ☐ Widowad 4 ☐ Divorced WHITTE 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Collaga (1-4or 5+) Elamantary/Sacondary (0-12) PSYCHO THERAPIST 5+ PSYCHIATRIC 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) MORRIS SIVRANSKY ELIZABETH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) DR. HAROLD P. HALPERT/HUSBAND ITEM #10 SAME AS 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 🎇 Cramation 3 ☐ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 5/19/98 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility 20910 M00091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Part1. Entar tha diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) days Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaase or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 □ Yas 2 □ No 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Impatiant 2 ER/Outpatient 3□ DOA

physician and the burial-transit 980 page 2 certificate this ne Hospital or Attending PI n 24 hours after death. Ne Funeral Director: After the pletely filled in by the funera

Physician

/Medical

Examiner

Funeral

Director

e notified at

8 Items 23s

'natural', or

Hygiene.

spartment of Health, important: if Item 27 is any injury or other once.

Physician

/Medical

Examiner

1 and 2 should be Health and Mental marked Director

Funeral

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Completed

Be

Physician/Medical Examiner þ Completed Be 2 Certification:

1 Yas 2 No 27. Manner of Death

5 Panding invastigation 2 Accident 6 Could not be datarmined 3 ☐ Suicida 4 Homicida

28a. Data of Injury (Month, Day Yaar)

28c. Injury st Work? 1 Yas 2 No 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one)

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar stated.

29b. Signatura and title of certiflai

29c. Licansa number 033357

5530 Wisconsin Ave

29d. Data signed (Month, Day, Year)

30. Name and addrass of parson who complated causa of death, (Itam 23a) (Type, Print) m JonaThan

31. Data filad (Month, Day, Yaar)

MAY 2 0 1998

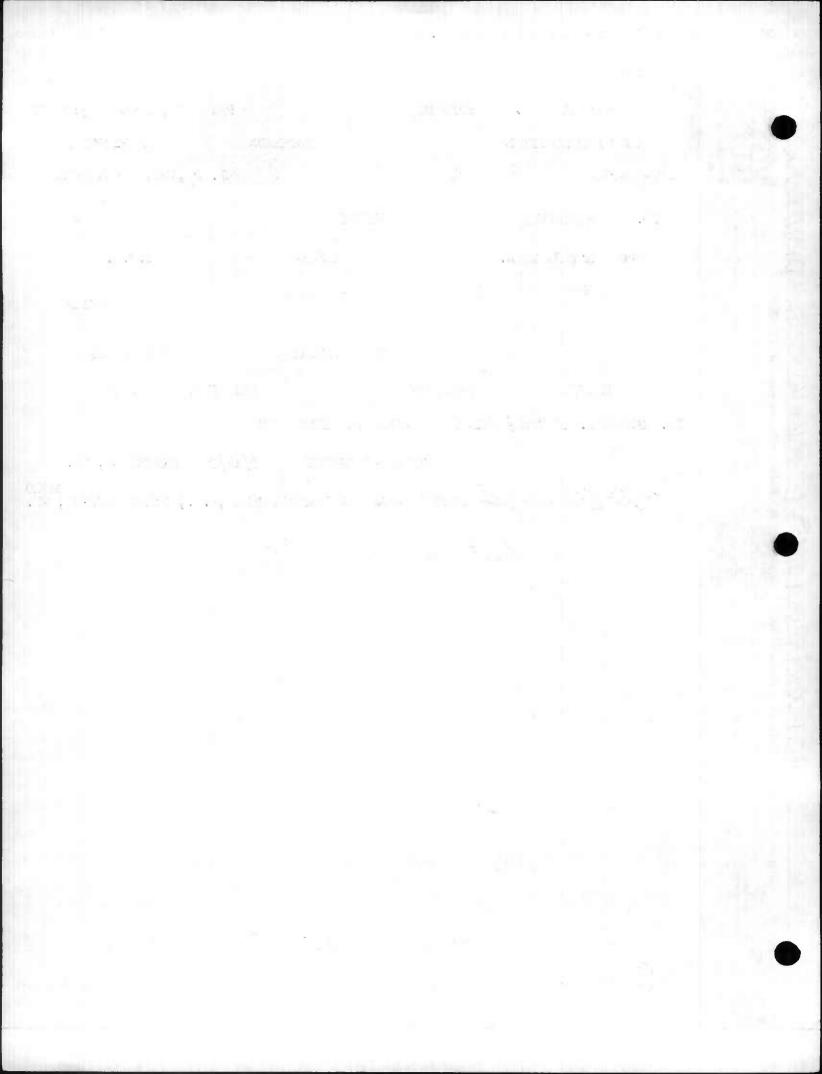


State Registrar

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Division of Vital



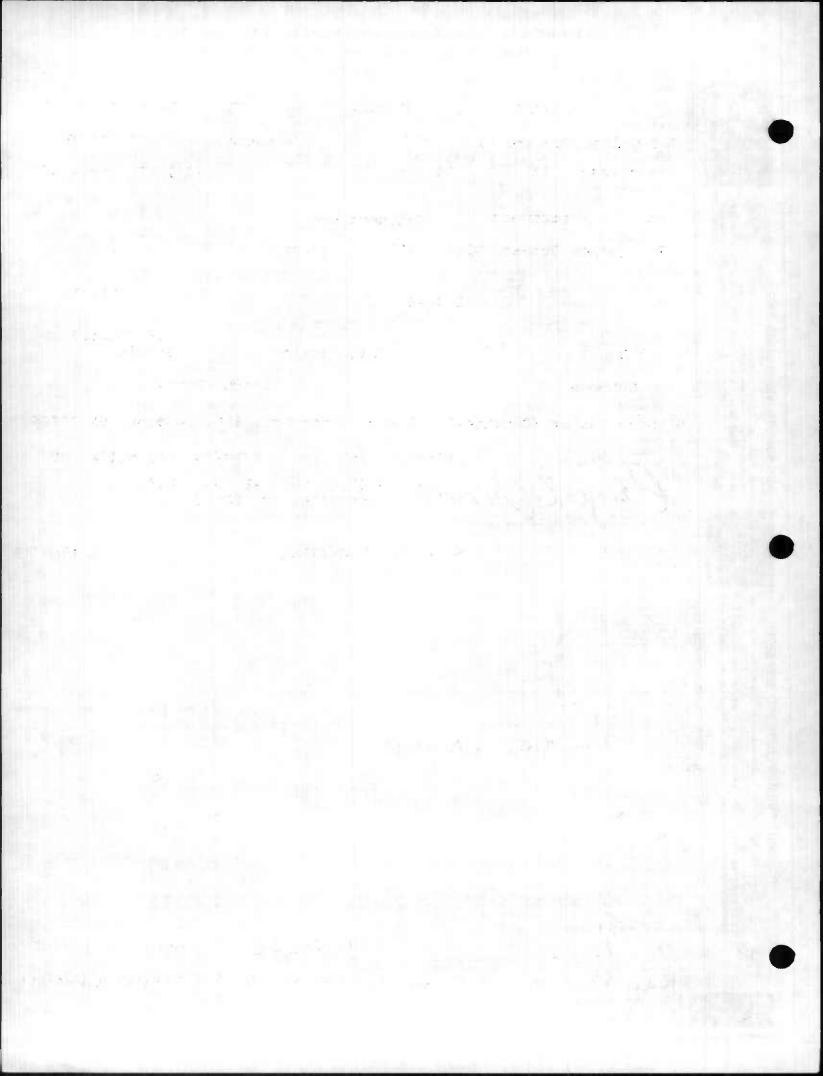
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 13, MAY 1998 11:55 P J. HARRIS THEODORE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Gaithersburg MONTGOMERY 783 Quince Orchard Blvd., #21 If Under 24 Hrs.
Hours Min.

No. (Month, Day, Year)
Dec. 19, 1913 If Under 1 Year 5. Social Security Number 8. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Funeral | Months 10 M 20 F Days Wash. 84 577-07-6300 Director Usuai Residenca of Decedent with the Maryland 10d. Insida City Limits 10c. City. Town or Location 10a, Stete 10b. County 7 is marked other than "natural", or flems 23s or 28s-1 show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Montgomery Director MD Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 783 Quince Orchard Blvd., #21 20878 U.S.A. Funeral death 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Health and Mentel Hygiene. I important: if item 27 is merked other than "natural", or item any injury or other traumatic event. In Yes 2 No 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Year or Detes: 1944-45 ٥ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Postal Elamantary/Secondary (0-12) Collega (1-4or 5+) 7th Mail Carrier Service 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Blanche Perry Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1 Sacramento Dr., #85, Hampton, VA 23666 Blanche Tucker (Daughter) 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from Stata 5/19/98 Lincoln Park Cem. Rockville, MD 4 Dopation 5 Other (Specify) of Fameral Service Licens 22 Name and Address of Facility RAL HOME, P.A. Bru ROCKVILLE, MD 20850 23a. Part1. Enter the please, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart foliare. List only one cause on each line. Approximata Intervat Batween Onset and Death **Physician** /Medical Immediate Cause (Final RECTAL CANCER 2 MONTHS disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician end the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Lasf Due to (or as a consaguanca of): Records, P.O. Box 68760 Physician/Medicai Due to (or as e consequence of): ed by the aideled for Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown signed t þ PROSTATE CANCER 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peeu has page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vitai or Attending Physician: after death. Director: After this certifica funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Dey Year) Certification: 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accidant 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be datarmined 3 Sulcide 28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 T Homicida Hospital
 24 hours a
 Funeral edical In the lime, ng Physician: To the best of my knowledge, death occurred at the time, data and piace, and due to the cause(s) and manner as stated.

The death examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) 29a. Certifier (Check only one) To the To the To the I and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature of D 28656 15 2642 . Name and address of person who completed cause of death (Item 23a) (Type, Print) SECOND AVE, #404 B S. SPKING MD20910 MD 8609 31. Date filed (Month, Dey, Year) 32, Ragistrar's Signature State MAY 1 9 1998 Julia Savidson-Randall Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

					Cer	tificate o	f Death		Reg. No. 9		7059
	Physici	an	1. Decedent's Name (First, Middla, Last)		41	11	2. Date of De Month	Day	Year	3. Time of Death
	/Medi	al	ERDINE	D.		/[/	LL U. Ohr Town	May 15		15	9:20 PM
	Examir	ier	4a. Facility Name (If not Institution, give				4b. City, Town, or				Ta bell III o
r	Funeral		Suburban Hospital 5. Social Security Number 6. Se		rs. lest birthday)	If Undar 1 Ya	Bethesda ar If Undar 24 Hr			gomer	
	Funeral Director			DM 2⊠F 78	Yrs.	Months Day	s Hours Mir	8. Date of Bi (Month, Do	ey, Year)		ace (Stete or Foreign ry) sylvania
١,	0		Usual Residence of Decedant					mar . Z	7,1720	I CIIII	syrvania
	ahow	4	10a. State 10b. County	10c.	City, Town or Loc	cation				10	d. Inside City Limits
	the Marylar 28a-f show	Director	Maryland Montgome	ery	Silver S						1 ☐ Yes 2 ☐ No
	A S		10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	seth w	eral	1705 Mayhew Drive	12. Was Decedent Ever in	118 12 1	Vac Decedent o	20902	Coosifu Van or No	USA	e - America	n Indian
120	filed within 72 hours after deeth with the Maryland Hygiene. thet than "natural", or items 23a or 28a-f ahow int, the Mod cal Examinal must be nothed at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Giva Year or Dates:		Yes, specify C	f Hispanic Origin? (uban, Mexicen, Pue lo <i>Specify:</i>	into Ricen, etc.)	Bia Specifi	ck, White, e	otc.
21215-0020	"natural",	edt	15. Decedant's Edu	cetion	16a. Deced	ant's Usual Occ	upation		16b. Kind of B	White	
215	hin 7.	plet	(Specify only highest grad Elamantary/Secondary (0-12)	e completed) Coilege (1-4or 5+)	(Giva I	kind of work dor O NOT use ret	e during most of w	orking			,
21	y the	Com	Elamanary/5000mdary (5-12)	2	Pharm	acy Tec	hnician		Medica	1	
Pu	al Hy d othy	Be Completed	17. Father's Name (First, Middla, Last)				18. Mother's Na	ame (First, Middle	, Meiden Suman	ne)	
yla	Meni	Lo	Raymond Oliver				Grace	Eins	ig		
Maryland	l sh is m raum		19a. Informant's Name/Relationship (T)				et end Number or F				
	1 and Health		Hermon H. Hill, J.				rive Siv	vler Spr	ing, Mary		20902
ō	nt of nr of its		1⊠ Buriai 2 ☐ Cremation 3 ☐ F	temoval from State	cematery, crem					•	
Baltimore,	permit. Peges 1 and 2 should be filed withir Depertment of Health and Mental Hygiene. Important: If itsm 27 is marked other than any Injury or other traumetic event, the Manage.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		edar Hil				Suitlan		yland
B	Depe Impo any I		1	. 0			rass of Facility Collins				
	_		23a. Part Lanter the disease, or composhock, or heart failure. List only o	ications that cannot the de	50 eath. Do not ente	O Unive	rsity Bly	vd.,W.,S	ilver Sp	ring,	MD 20901 Approximate
-	Physician		shock, of heart failure. List only o	ne cause on each life.					·		Interval Between Onset and Death
	/Medical		immediata Cause (Final disease or condition	RESPIRA	TORY	FAILL	IRE			1	
	Examiner		rasulting in daath)		(or as a consequ						
	ed sit	line		0. ————						i	
	icete be executed physician and s the buriel-transit	Examiner	Sequentially ilst conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disaase or injury	Due to	(or as a consaqu	uence of):					
68760,	siclan burie	alE	ceusa. Enter Underlying Cause (Disaase or injury that initiated avants							i	
89	tificete ng phy es the	Medical	rasulting in death) Last	Due to	(or as a consequ	ience of):					
Box	ettending for use	M/u		d,							
	ne death the ette hed for	sicia	Part li. Other significant conditions co	ntributing to death but not r	esulting in the un	deriving ceuse	given in Part I.	23b. Did	tobacco uss co	ntributa to	the cause of death?
s, P.O	es that the de igned by the be detached	by Physician/I		ulc obsta					Yss 2□No	3 Probe	
Division of Vital Records,	been should	Completed	DISGRE, ATRI	AL FIBR			MEDIA	24a. Was	an autopsy ormed?	com	re autopsy tindings ilable prior to apletion of causa laath?
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ita	ician: Th certificate rector, pa	Be (25. Was cese refarred to medical examiner?	1			26. Placa of De	eath (Check only	ona)		
5	Physic this co	2	1 ☐ Yas 2 No		☐ ER/Outpatient	3LI DOA		Home 5□Res)
UC C	After 1	inol	27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day Year)	28b. Time of Injury	28c. in		28d. Describe	how Injury occur	red	
Sign	the eet	cat	2 Accident investigation 3 Suicide 6 Could not be	28a. Piace of injury - Ai	home form etre		Yes 2 No	28f Location	(Street end Numl	her or Rural	Route Number
Θ	after d Direct d in by	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)	ot, factory, offic		City or To	wn, Stata)	oor or vidiar	riodia rionosi,
_	To the Hospital or / within 24 hours after To the Funeral Directorpletely filled in the completely filled in the complete		29a. Cartifiar Cartifying Phy	sician: To the best of my k	nowledge, daath	occurrad at tha	time, date and place	ce, and due to the	causa(s) and m	anner as sta	ated.
	n 24 ho Ho	edical	(Check only 2 Medical Exami	ner: On the basis of exami and mannar stated.	nation and/or inv	estigation, In m	y opinion, daath occ	currad at the tima,	data and place,	and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and time of carrier	- 44		29c. Lice	nse number		29d. Date signe	d (Month, D	ley, Year)
	10		Man	MINIO		02	6571		5/16/	48	
			30. Nama and address of person who of	m lated cause of death (II	tem 23a) (Type, F 4930	Print	RAY A	UE BE	ETHESI	04,1	10 208/2

32. Ragistrar's Signature

Jahra Davidson-Randall

DHMH 16 Ray 6/95

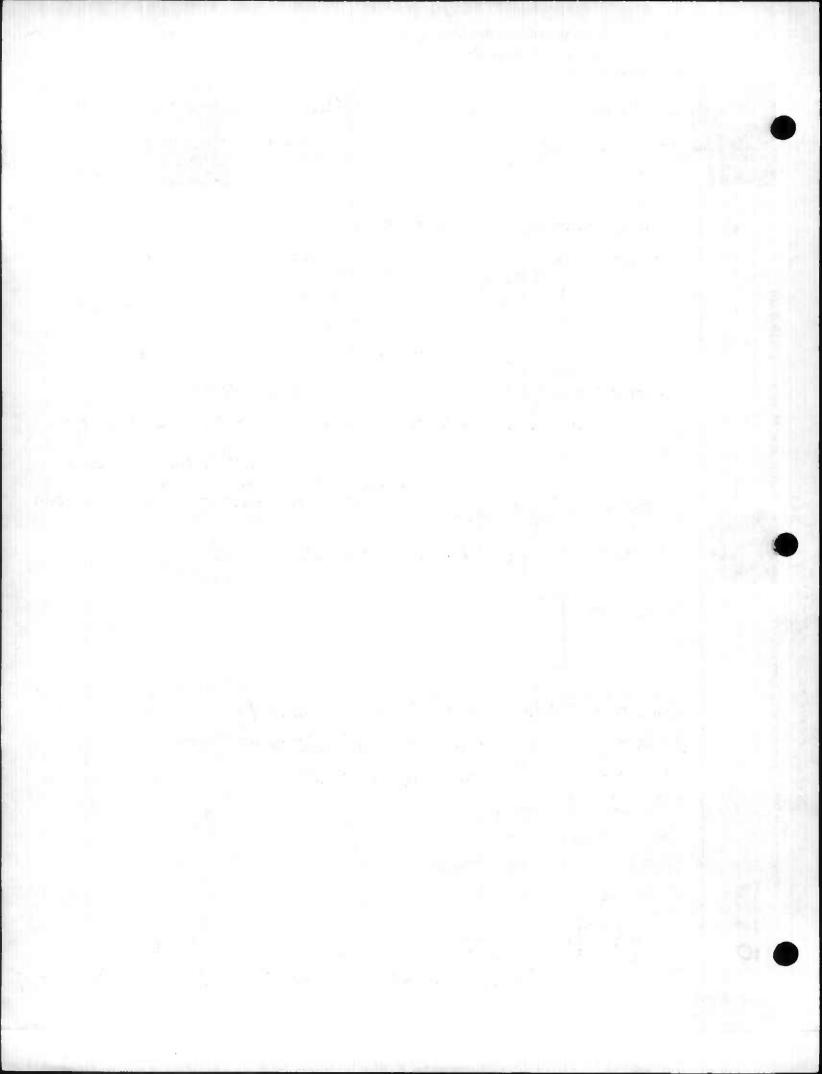
State

Registrar

31. Date filed (Month, Dey, Year)

MAY 1 8 1998

HILL, ERDINE



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month

Physician /Medical Examiner

Funeral Director

with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mertal Hygiene. Int: If item 27 Ia marked other than "naturel", or items 23a or 28a-f ehow ary or other traumatic event, the Medical Examiner must be incitted at

Baltimore, Maryland 21215-0020 permit. Page Department of Important: If any Injury or

> **Physician** /Medical **Examiner**

physician and s the bunal-transit 65 USB 0 signed by the aid should page 2 has certificate funeral director, After this

O. Box 68760.

Records,

Division of Vital

that the death certificate be executed or Attanding Physician: 24 hours after death.

Funeral Director: A filled in by Hospital To the Within 2 To the

1. Decedent's Name (First, Middle, Last) 3. Time of Death Margaret West Bauer Horan May 21, 1998 4:30 am 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 12716 Huntsman Way Potomac Montgomery If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) July 3, 1937 5. Social Security Number 7. Age (In yrs. lest birthday) 9 Birthplace (Stete or Foreign Country) Days 1 M 2 F Months Hours Yrs 60 Ohio 296-34-1630 Usual Residance of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County 1 ☐ Yes 2 No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12716 Huntsman Way 20854 United States Funeral Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status 12. Was Decedant Evar in U.S. Armed Forces?

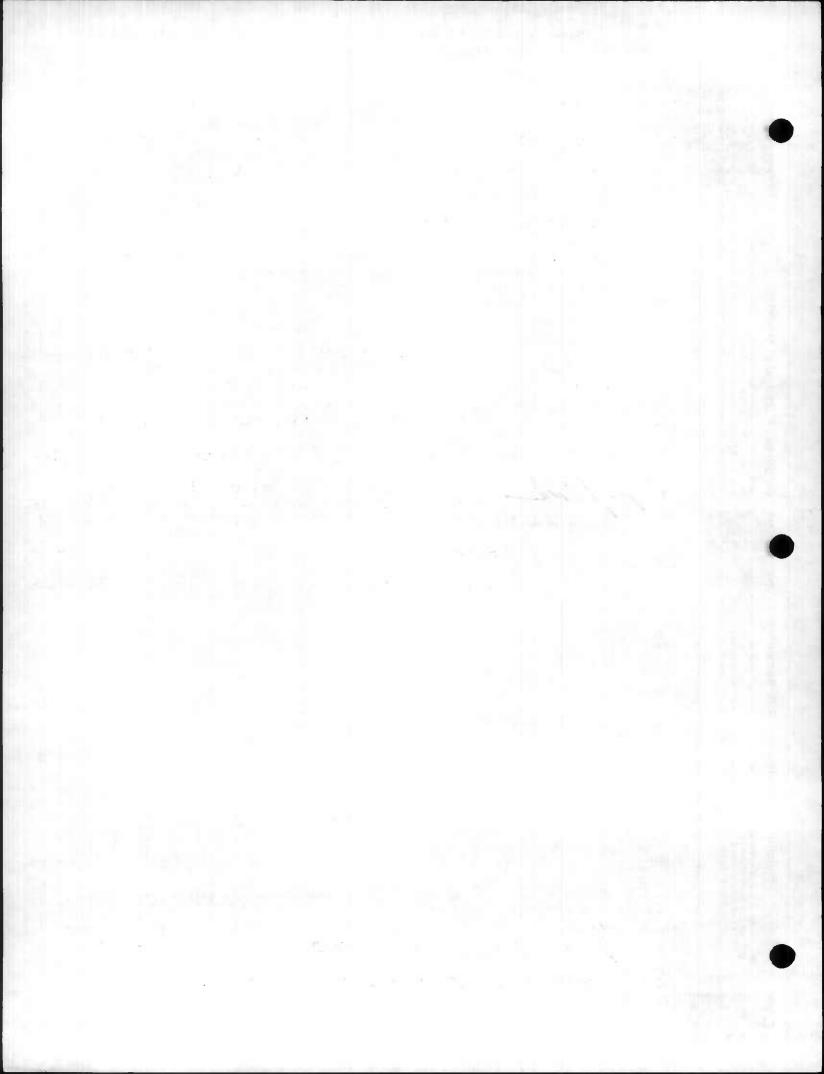
1 Yes 2 No
If Yas, Giva Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ United Methodist Church Music Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Helen Fiscus Howard H. West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Robert L. Horan - Husband 12716 Huntsman Way, Potomac, Maryland 20854 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata 20a. Method of Disposition emetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-22-98 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility
Rapp Funeral Services, P.A. 21. Signatura of Juneral Saprice June (M00956)933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxemia 8 hours disaase or condition resulting in death) Due to (or as a consequence of): 10 months Examiner Cancer of the Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the ceuse of death? 1 XY00 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 No 8 26. Place of Death (Check only one) Other: 4□ Nursing Home 5 🗓 Residence 6 □Other (Specify) 70 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of Certification: 1X Natural 5 Pending 2 No 1 Yes investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier 🔭 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated. (Check only one) 2 Madical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signatura and tity of certifian 29d. Data signed (Month, Day, Year) 29c. Licansa number 2577 May 21, 1998 mere

State Registrar

31. Date filed (Month, Day, Year) MAY 2 2 1998



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middla, Last) 2. Deta of Death 3. Time of Death **Physician** HORN 1220 A ROBERT ,1998 MAY /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number, 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL BOCKVIIIE 19. S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Wonths Devs Hours Min. (Month, Day, Year) MONTGOMERY Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Months Deys Hours 55 Yrs. 215-38-3486 November 11, 1942 Director Maryland Usual Rasidence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "naturel", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 11 Bentridge Court 20854 United States Funerai 14. Raca - Americen Indian, Black, Whita, atc. 12. Wes Decedant Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puano Ricen, atc.) 11 Marital Status of filed within 72 hours after if Hygiene. 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Datas: 1 □ Never Married 20% Married 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) Collega (1-4or 5+) Project Engineer Federal Government 18. Mother's Nema (First, Middla, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be fits Department of Health end Mentel th Important: if item 27 is marked oth eny linjury or other treumatic event place. Melvin R. Horm Aileen Webster 19a. Informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 11 Bentridge Court, Potomac, Maryland 20854 Mary C. Horm/Wife 20b. Place of Disposition (Nama of cematary, crematory or othar placa) May 18, 1998 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Burlal 2 ②Cramation 3 ☐ Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Nema and Addrass of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licenses Rockville, Inc. 300 West Rockville, Maryland 20850 300 West Montgomery Avenue M00198 23a. Pan1. Enter the disease, or complications that ceusad tha death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disease or condition rasulting in deeth) /Medical ADENOGARCINOMA OF UNKNOWN PRIMARY SITE Examiner Due to (or as e consequance of): Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daeth) Lest Due to (or as a consequence of): ettending physician for use as the bure Physician/Medical Dua to (or as a consequence of) the 88 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to daeth but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 99 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed certificate has 2 No 1 Yas 1 ☐ Yas 2 ☐ No s offer death.

I Director: After this certificat 25. Was cesa refarred to medical Be 26. Placa of Daeth (Chack only ona) axaminar? 1 Yas No Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Inpatiant 3□ DOA Lo 2 ER/Outpatient 27. Mannar of Death 28d. Dascribe how injury occurred Certification: Injury at Work? 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

Division of Vital Records.

the death certificate be exec P.O. Box 68760,

with the Maryland

Baltimore, Maryland 21215-0020

To the Hospital of within 24 hours of To the Funeral D D

> State Registrar

Medical

4 Homicida

29b. Signatura and title of certifia

31. Data filed (Month, Day, Yaar) MAY 1 9 1998

29a. Cartifiar

29c. Licansa number

Certifying Physician: To the best of my knowladga, daeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

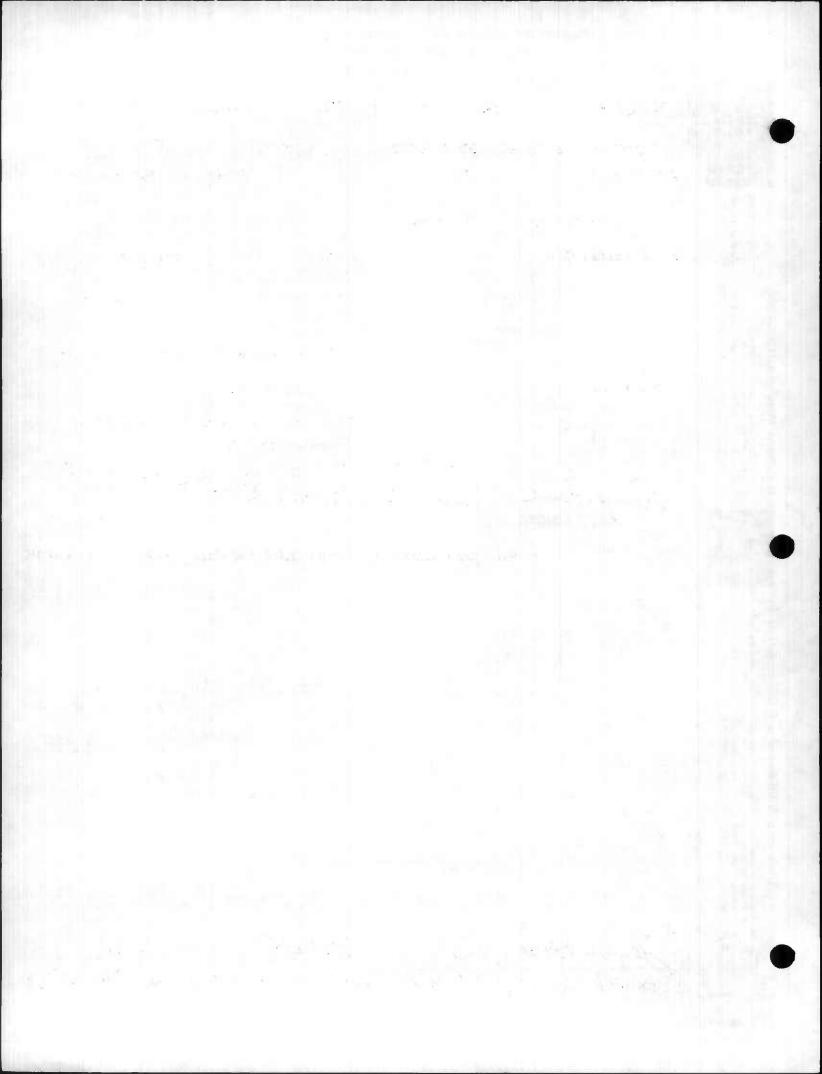
2 Medicat Examiner: On the best of axeminetion end/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

completed cause of death (Item 23e) (Type, Print)

gillia Davidson

9707MEDICAN CENTER DRIVE KOCKWINE MD 20850 32 Ragistrar's Signatura

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 98

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	Funeral Director		5. Sociel Security Number 215 • 44 • 8283	6. S	ex StM 2□F	7. Age (in yrs. lest b	virthdey) Yrs.	If Under Months			Min.	8. Date of E	Birth Day, Ye 28,	1910	Col	plece (Stete or Foreig intry)
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Baltimore,	Pages 1 and ent of Health nt: If Item 27 ry or other to		20e. Method of Disposition			20b. Piece cemer	bb. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete								own, Stete		
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	Physician /Medical		23a. Pert1. Enter the disease, shock, or heer feilure. List Immediate Ceusa (Final disease or condition	or comp st only			e death. Do	o not ente	er the mod	le of dy	ring, such e	s cardiac	or respiretory	errest,			Approximete intervei Between Onset end Death
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R	0 5 0	mo.											10	Yes	2 No		☐ Yas 2☐ No
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Y	d is	To	exeminer?		Hospital: 1 🗆 I	npatient	2 🗆 ER/0	Outpatien	t 3□ DC	OA O	ther: 46 N	lursing H	ome 5 Re	sidence	6 □Oth	er (Spec	ity)
ion of	Attanding Ph or death. octor: After thi by the funeral		27. Manner of Deeth 1 Neturel 5 Pend 2 Accident Inves	ling tigation	28e. Dete d (Mont	of Injury h, Dey Y	(ear) 28b	. Tima of Injury	M 2	8c. Inj	uryat ork?]Yes 2[28d. Describ				
Division	l or Attandi after death. Director: A d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be mined	28e. Plece buildin	of Injury ng, etc. (- At home, Specify)	ferm, stre	eet, factory	y, office)		28f, Location City or 7			oer or Ru	ral Route Number,
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 XCartify (Check only one) 2 Madica	ing Phy	yelclan: To the niner: On tha ba end mann	asis of ex	aminetion e	ga, daath end/or inv	occurred restigation	et the t	time, dete e opinion, de	end plece	, end due to the	ne ceuse e, date	e(s) end me end plece,	enner as end due	steted. to the ceuse(s)
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					M.D. P					PH	ILIP 1	DRIV	E, #209	9, 0	LNEY,	MAF	RYLAND 208:

Registrar DHMH 16 Ray 6/95

ABRY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death ERNEST HUTCHESON 20 1998 MAY 2:50 PM 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY 7. Age (In yrs. last birthdey) If Under 1 Year if Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) Hours Deys 1 XM 2 F Months Min 89 214-05-4860 Feb 24,1909 MARYLAND Usuel Residence of Decedent 10b. County 10c, City, Town or Location 10d. inside City Limits

10f. Zip Code

21502

1 Yes 2√ No Specify:

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

 Was Decedent of Hispenic Origin? (Specify Yes or Noif Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

CUMBERLAND

MANAGER

 Piace of Disposition (Neme of cemetery, cremetory or other place)

THOMAS HUTCHESON/NEPHEW 105 E RING FACTORY RD,

1 Yes 2 No

10g. Citizen of Whet Country?

14. Race - American Indian.

WHITE

Bleck, White, etc.

USA

18. Mother's Neme (First, Middle, Meiden Surneme)

MARY MARSHALL

Dete MAY

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

Specify:

16b. Kind of Business/Industry

FINANCIAL

20c. Location - City or Town, Stete

BEL AIR, MD 21014

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene important: If the 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other treumstic event, the Modical Evaniner must be notified at once.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

MARYLAND

11. Maritai Stetus

10e. Street end Number

ALLEGANY

12. Was Decedent Ever in U,S. Armed Forces?

Yeer or Detes: WW II

I ∑ Yes 2 □ No If Yes, Give

College (1-4or 5+)

S L SANDHIR, 48 TARN TERRACE,

MAY 22 1998

32. Registrar's Signature

Jaki Blevilson Brilis

951 SETON DRIVE APT

ROBERT M. HUTCHESON

1 ☐ Burlel 2X Cremation 3 ☐ Removal from Stete

19a. Informant's Neme/Relationship (Type, Print)

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Merried

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondery (0-12)

17. Fether's Neme (First, Middle, Lest)

12

20e. Method of Disposition

Physician /Medical Examiner

Attending Physician: The lew requires that the death certificate be executed buriel-transit Box 68760, for use as the P.O. ate hes been signed by page 2 should be detac Records, certificate Division of Vital director. this funeral After death. spital or Attendinours effer death To the Hospital c within 24 hours of To the Funeral D completely filled Hospital of

4 ☐ Donetion 5 ☐ Other (Specify) SILBAUGH CREMATORY 22,1998 UNIONTOWN, PA Signature of Funeral Service Licenses 22. Name end Address of Fecility HAFER CHAPEL OFTHE HILLS MORTUARY 23e. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. 21502 Approximete interval Between Onset and Deeth immediete Cause (Finel myocardul in farctin acute diseese or condition resulting in deeth) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown gestive beent Failure. ģ Be Completed 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? live, Anemia - Hypothy rordis Fractive 3 pme 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medice examiner? 26. Piece of Death (Check only one) Hospitel: 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28e. Dete of injury (Month, Dey Year) Certification: 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Medical 29a. Certifler 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. TEL CERTIFYING PROGRET TO the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 21. 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

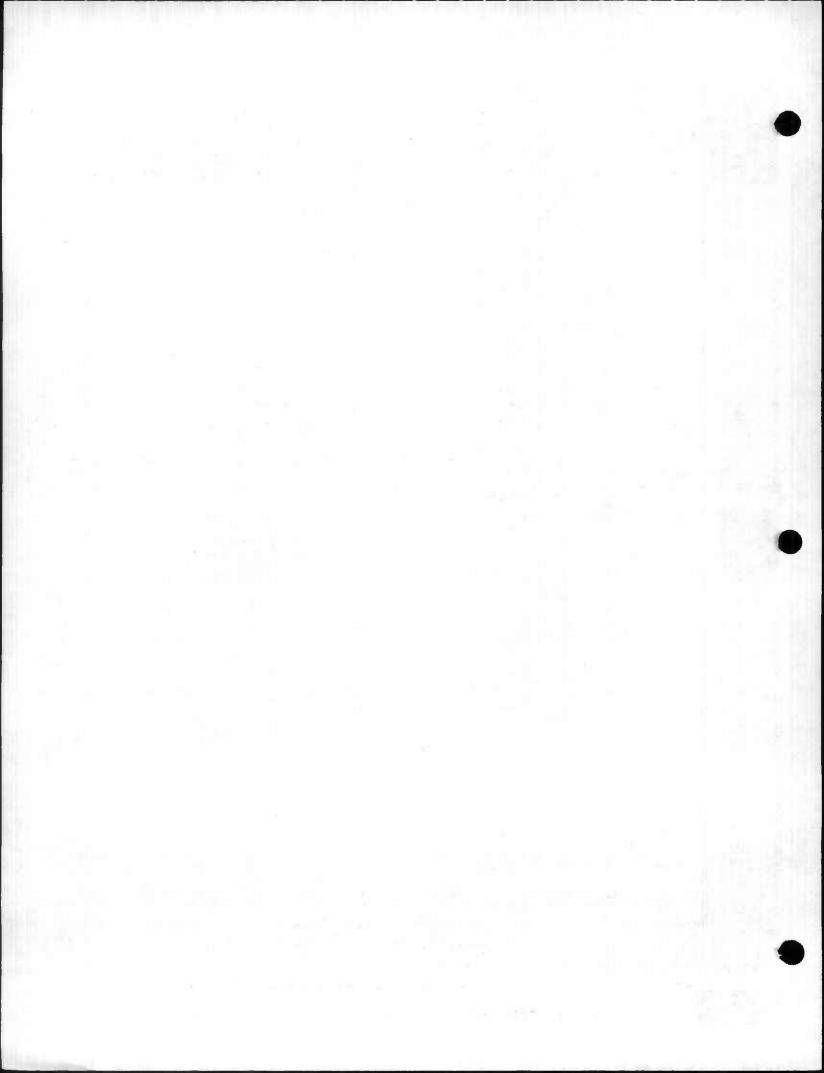
FROSTBURG, MD

21532

State Registrar

31. Date filed (Month, Dey, Year) _

New



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death Month **Physician** Helmick 05 Jolores /Medical 4e Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical System Baltimore,
6. Sex 7. Age (In yrs. lest birthdey) If Undar 1 Year If Undar 24 Hrs. University of Baltimore 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2점 F 64 Yrs 2/6-30-/6%2 Usuel Residence of Decedent **Director** Maryland with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Examinar must be notified at cumberland Allegan 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? USA Race STreet 21502 311 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, Whita, etc. 11. Meritel Status permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or iter any injury or other treumetic avent, the Medical Examinat ONCE. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Saltimore. Maryland 21215-0020 1 ☐ Yes 2 🕱 No Spacify: þ white 3 ☐ Widowed 4 ☑ Divorced To Be Completed 15. Decedant's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOME Honemaker 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fether's Neme (First, Middle, Last) Meeks Gladys OSCOL 19e. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 2/5c 2 20c. Location - City or Town, State Terrace, Michael Case SON 9 West VIEW 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete May 1 M Burial 2 ☐ Cremetion 3 ☐ Removel from Stete cumberland, Md. 22,1998 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrost Mem, Park 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Leggure-Stein Funeral Home, 230 Baltimore 23e. Part1. Enter tha disease, or complications that caused the deeth. Do not anter the moda of dying, such as cerdlec or respiratory arrest, shock, or heart feiture. List only one cause on each line. 2 Approximata Interval Between Onset end Deeth **Physician** Immedieta Causa (Final diseese or condition resulting in daath) /Medicai f Pariet Interchanced

Due to (or es e consequence of): Examiner Examiner Hepstie failure
Due to (or as a consequence of): the attending physician end hed for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initieted events Box 68760. Congestive Physician/Medical Dua to (or as a consaquance of) resulting in death) Lest Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown Non insula dependent Diosetas Division of Vital Records. þ 24b. Wara eutopsy findings eveileble prior to completion of ceusa of deeth? 24a. Was an autopsy performed? Completed certificate has Yas 2 No 1 ☐ Yes 2 ☐ Ne 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) us after deeth.

eral Director: After this ce Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) P 1 Yes 2 No 1⊠Inpatient 2□ ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 1 Cartifying Physician: To the bast of my knowledge, deeth occurred et the tima, dete end plece, end due to the cause(s) end mannar as stated.

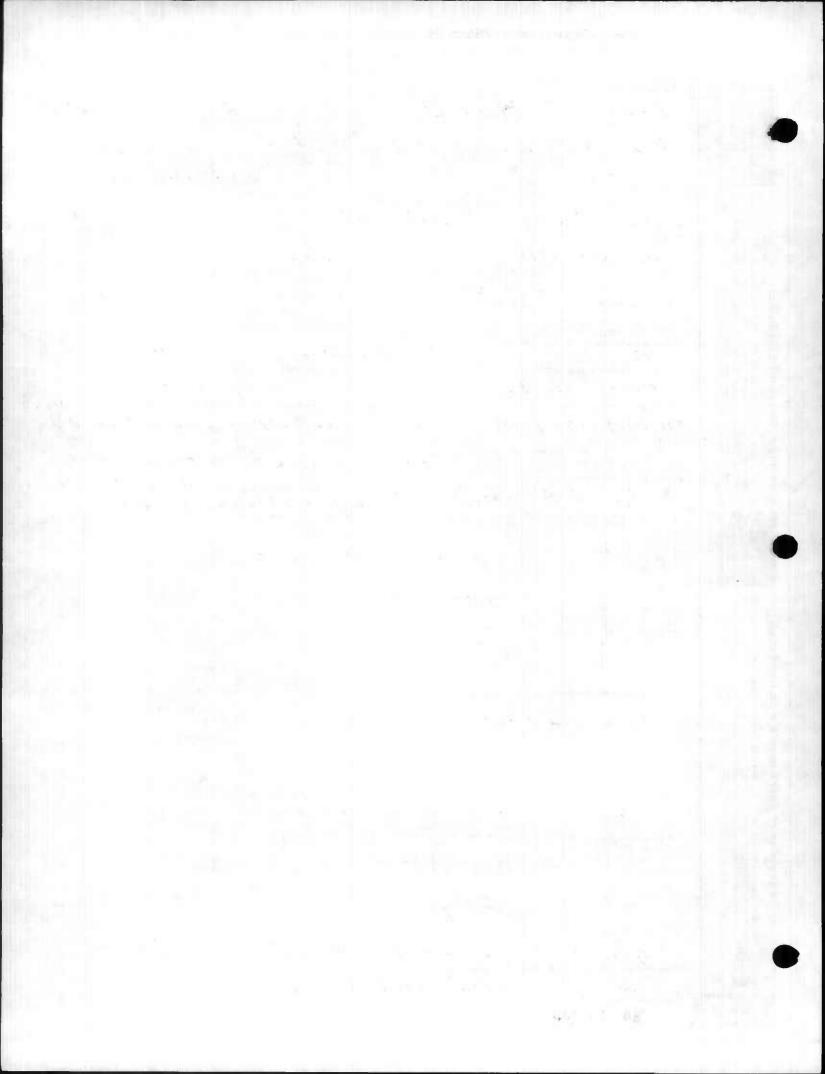
2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State Registrar 31. Data filad (Month, Day, Year)

MAY 21 1998

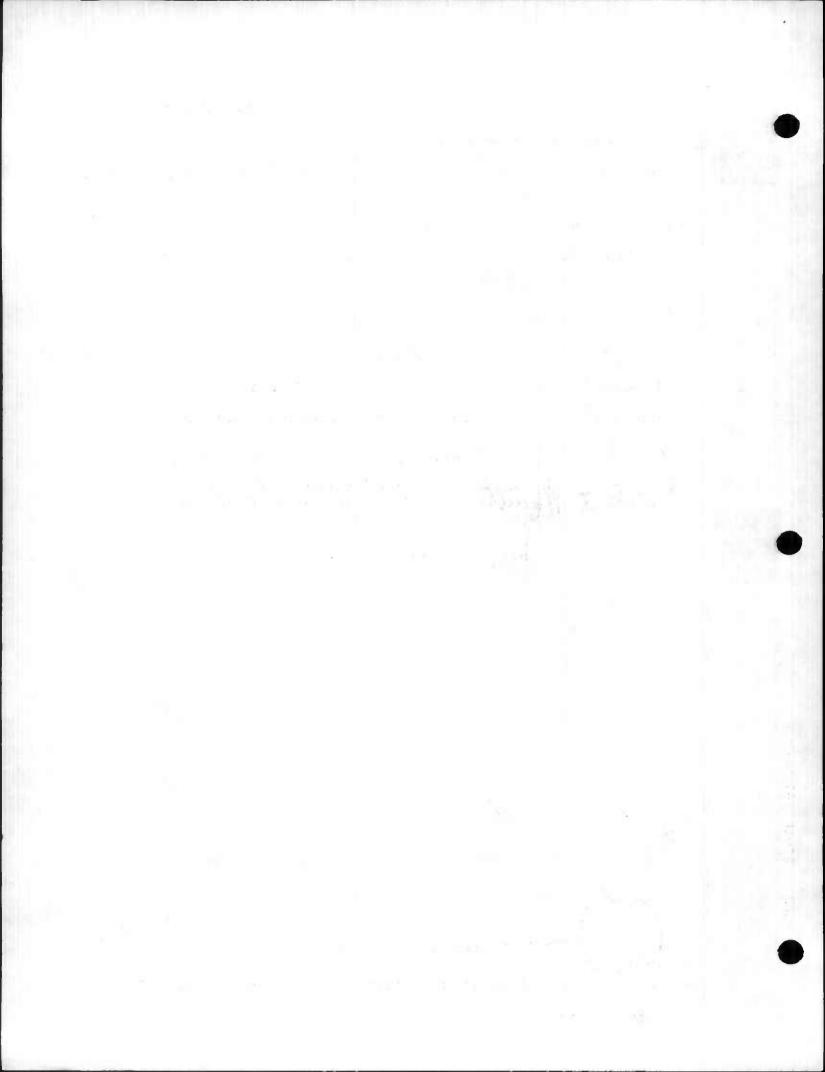
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

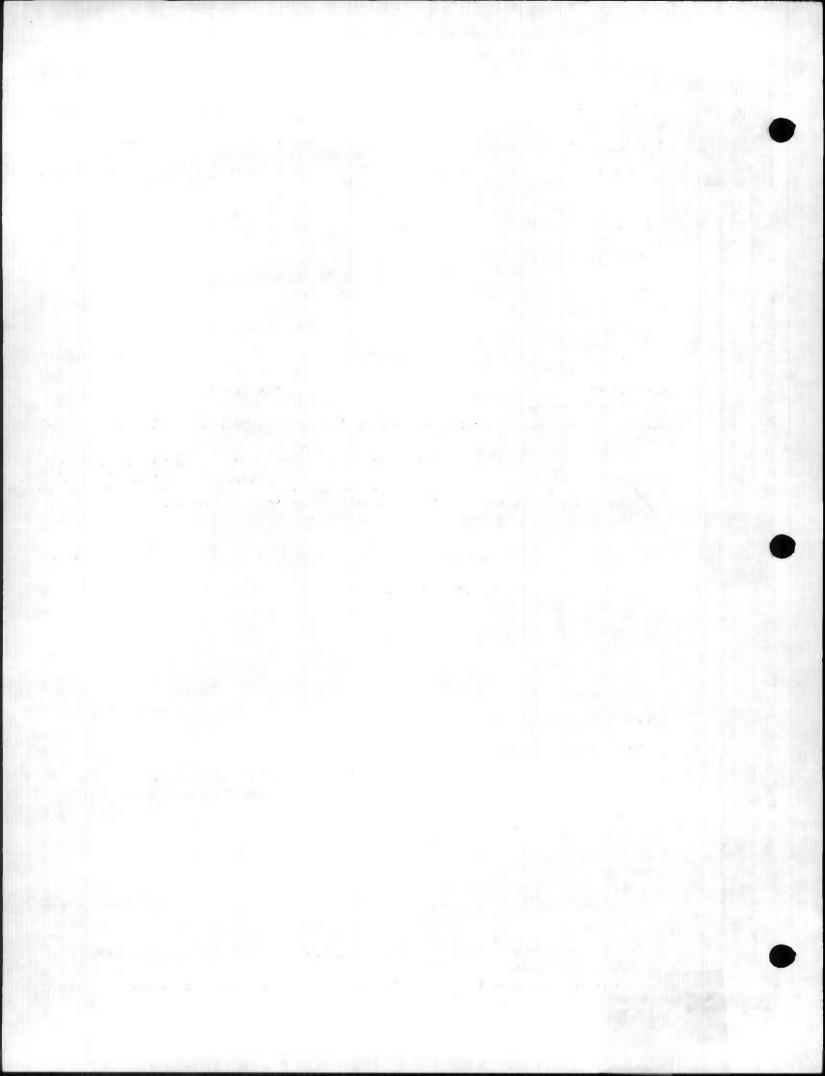
Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month **Physician** RICHARD WILLIAM 2:40 AM MAY 18 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MEMORIAL HOSPITAL MEDICAL CENTER CUMBERLAND ALLEGANY 5. Sociel Security Number 7. Age (In vrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) **Funeral** Birthplace (State or Foreign Country) Deys 1X M 2□ F Months Hours Min. Yrs. Director 705-10-5926 86 NOV 4 1911 MARYLAND Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo XX Yes 2 No MARYLAND ALLEGANY CUMBERLAND 10g. Cifizen of Whet Country? 10e. Street end Number 10f. Zip Code 502 PARK STREET Funeral 21502 death U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after ☐ Yes 2 No 1 Yes, Give 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: WHITE 3√Widowed 4 □ Divorced Decedent's Usual Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 B&O RAILROAD FOREMAN ON RAILROAD i. Pages 1 and 2 should be filed v tment of Health end Mentel Hygie tant: If Item 27 is marked other t ijury or other traumatic event, III Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be JOHN DANIELS HIXON EFFIE EYLER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DOROTHY AHERN NIECE RFD#2 BOX#181 RIDGELEY, W.VA. 26753 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 □ Buriel 2 □ Cremetion 3 □ Removel from State Depertment of important: If any Injury or 4 Donetion 5 Dother (Specify) DAVIS CEMETERY MAY 20 1998 CUMBERLAND MARYLAND 22. Name end Address of Fecility
MERRITT-ADAMS FUNERAL HOME 21. Signature of Funerel Service Lice 404 DECATUR STREET CUMBERLAND MARYLAND X 23a. Pert1. Enter the diseese, or complice shock, or heart feilure. List only one ons that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximete Intervel Between Onset end Death use on eech line **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Due p (or es e consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed bunal-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest pue Due to (or es e consequence of) RICHARD HIXON 705-10-5926 Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): 88 950 for be deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? the ed by No 1 Yes 3 Probably 4 ☐ Unknown þ should Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? has page 2 certificate 1 Yes 1 TYes 2 No funeral director, 25. Wes cese referred to medice exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: patient 1 Yes PONO Other: 4 Nursing Home Certification: To 3 DOA 2 ER/Outpetient 5 ☐ Residence 8 ☐ Other (Specify) this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funeral [ertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner as steted. Medical 29a. Certifie cal Examinar: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner stated. within 2 29b. Sig ature 29c. License number 29d. Date signed (Month, Dev. Year) 10 0 D 12779 rson who completed cause of deeth (Item 23e) (Type, Print) GUY FISCUS M.D., MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD 21502 31. Dete illed (Month, Day, Year) 32. Registrar's Signature State MAY 1 91998 Registrar



Physician						Cei	rtificate of	Death	1	Reg. No.		1000
- Martinal		lent'a Name <i>(First, M</i> etis A. J		t)					2. Date of De Month May 2	Day	Year	3. Time of Death 9:40PM
/Medical Examiner	4a Fecili	ty Neme (If not instit	itution, give		er)			4b. City, Town, or L	ocation of Dee	4c. County of Deeth Montgomery		,
Fire and		ckville N Security Number	ursir 6. Se		Age (In yrs. I	lest birthdey)	If Under 1 Year	If Under 24 Hrs.		rth		y ace (Stete or Fore ry)
Funeral Director		-34-7557	11	□M 2X)F	8		Months Deys	Hours Min.	Nov.	ay, Year)		_{y)} nsylvani
2		sidence of Deceden									1	
how	10a. Stat	10b. Co	unty		10c. City	, Town or Lo	ocation				10	d. Inside City Lim
or 28s-f	Mary		tgome	ry	Roc	kville						1 X Yes 2□
or 2	10e. Stre	et and Number					10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
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To Be Comple	Elemei	ntary/Secondary (0- 12	12)	College (1-4	or 5+)		emaker	-,		Own H	Iomo	
To Health and Mental Hygiene. If Item 27 ie marked other than or other traumatic event, to be To Be Comp	17. Fathe	er's Name (First, Mic	ddle, Last)			110111	emaker	18. Mother's Nan	ne (First, Middle	o, Maiden Sumem		
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d Ment marke matic		ormant's Name/Relat		'vne Print)		19b Mailir	ng Address (Street	and Number or Ru		her. City or Town	State Zio	Code)
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of Health Item 27 is r other tra		hod of Disposition	BILLVE	Ty/Daug	loot D	a A Diana	aldian (Alama of			20c. Location -		
or or or	10	Burial 2 Cremat			ate	emetery, crei	metory or other pla	^{ce)} May 22	1998	M		
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permit. Pages Department of H Important: If the any Injury or of	21. Sign	at Euheral Ser	VIOR LICENT	100		Re	thesda-Cl	ess of Facility Ro hevy Chas	bert A.	Pumphre 7557 W	y Fui	neral Ho
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/Medical Examiner	disease	ite Cause (Final or condition In death)		a. Gas		estina reseconsec	1 Bleedi	ng				2 Weeks
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physician and strength transit and control of the physician and control of	Sequent	ielly list conditions,		D		res e consec						
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Registrar

MAY 2 2 1998 Julia Davidson-Randelle



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	Physici	an	Decedent's Neme (First, Middle, L.	ast)					2. Dete of Month	Deeth Dev	Yeer	3. Time of Death
	/Medi		Elizabeth Ger						May		1998	10:00A
	Examir	ier	4e. Fecility Neme (If not institution, gi						, or Location of De		111 2111	
			Civista Medio					La Pla		Cha	rles	
	Funerai Director		229-28-9138	Sex 1□ M 2XF	e (In yrs. last birth	day) If Unde Months			Min. (Month,	Birth Day, Year) 31, 1901	9. Birthp Court Mar	elece (State or Foreign http:/ yland
	pue *		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
	Sa-f eho	ector	Maryland Charle	es	Pomf							1 □ Yes 2 No
	ith g	D C	10e. Street end Number	_			p Code	_		10g. Citizen of	Whet Cour	itry?
	eth v	rai	5520 Raphael S				067			USA		
5-0020	72 hours after deeth with the Merylend naturel, or items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	11. Maritel Status 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced		1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2		dent of cify Cu 2 XNo		? (Specify Yes or duerto Rican, etc.)	14. Race - American Inc Bleck, White, etc. Specify: White		etc.
15-0	nd 2 should be filed within lith and Mental Hygiene. 27 is marked other than ° r traumatic event, the Me	Completed	15. Decedent's E (Specify only highest gi	rade completed)	16e. D	ecedent's Usu Give kind of wo	el Occu ork doni	upetion e during most of ed)	working	16b. Kind of E	lusiness/in	dustry
2121		E O	Elementery/Secondary (0-12)	College (1-4or !)+)	memak		,		Но		
		Bec	17. Fether's Neme (First, Middle, Las	t)				18. Mother's	Name (First, Midd			
ylaı		ToE	Archie Wingate				Eliza	abeth Co	ooksey	Wing	ate	
Maryland			19e. Informent's Neme/Reletionship Jewell Thompson						r Rural Route Nur Plata,			Code)
altimore,	00-		20a. Method of Disposition 1 Burlel 2 Cremetion 3 4 Donetion 5 Other (Special Contents)	□Removel from State	20b. Pleca of D Cedar,	isposition (Na Grematory or o	me of other pl	netery	5/23/	98 Suit		
Balt	permit. Pag Department Important: Il eny injury o		21. Signature of Funerel Servica Lice	Elis 7	100817				Funera La Plata			
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Re	mul	1 4	cert	are				36 h.
		Jer		C	Due to (or es e co	nsequence of)	:		1 /) <i>L</i>	1	10 da
	dansit	Examiner	Sequentially list conditions	Ь.	Due to (or es e co	nsequence of):	Sas	and an	accia			100-
68760,	certificete be executed rding physician end use as the bunel-transit		Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest	c. Cer	Texas Due to (or es e cor	2och	٤ (Cordia	vacle	dise	ex 10	yes
Box 6	certif ding ise a	clan/Medical		d			_					
	dea e att		Pert II. Other significant conditions	contributing to death b	ut not resulting in the	ne underlying o	cause g	iven in Pert I.	23b. D	id tobacco usa co	ntribute to	the cause of death?
s, P.O	requires that the de wen signed by the s hould be detached	by Physi	Mm-msel	Depend	of de	rhh	d	alle	1	□ Yes 20 No	3 ☐ Prol	bably 4 Unknown
Vital Records,	require been s	Completed b							24a. W	es en eutopsy normed?	CO	ere eutopsy findings eileble prior to mpletion of cause deeth?
R	0 - 0	Con							1[Yes 200 No	1 🗆	Yes 20 No
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-	yslcia is cert direct	2	1 Yes 2 No	Hospitel: 1 Inpatie	nt 2 ER/Outp	atient 3 D	O AC	ther: 4 Nursi	ng Home 5 🗆 Re	sidenca 6 🗆 Oti	ner (Specify	v)

To the Hospital or Attanding Physicities 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral directors. Division of Certification: Medical

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end menner stated.

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

29b. Signeture end title of certifie

5 Pending investigation

6 Could not be determined

27. Menner of Deeth

1 Neturel

2 Accident

3 Sulcide

4 | Homicide

29a. Certifier (Check only one)

28b. Time of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

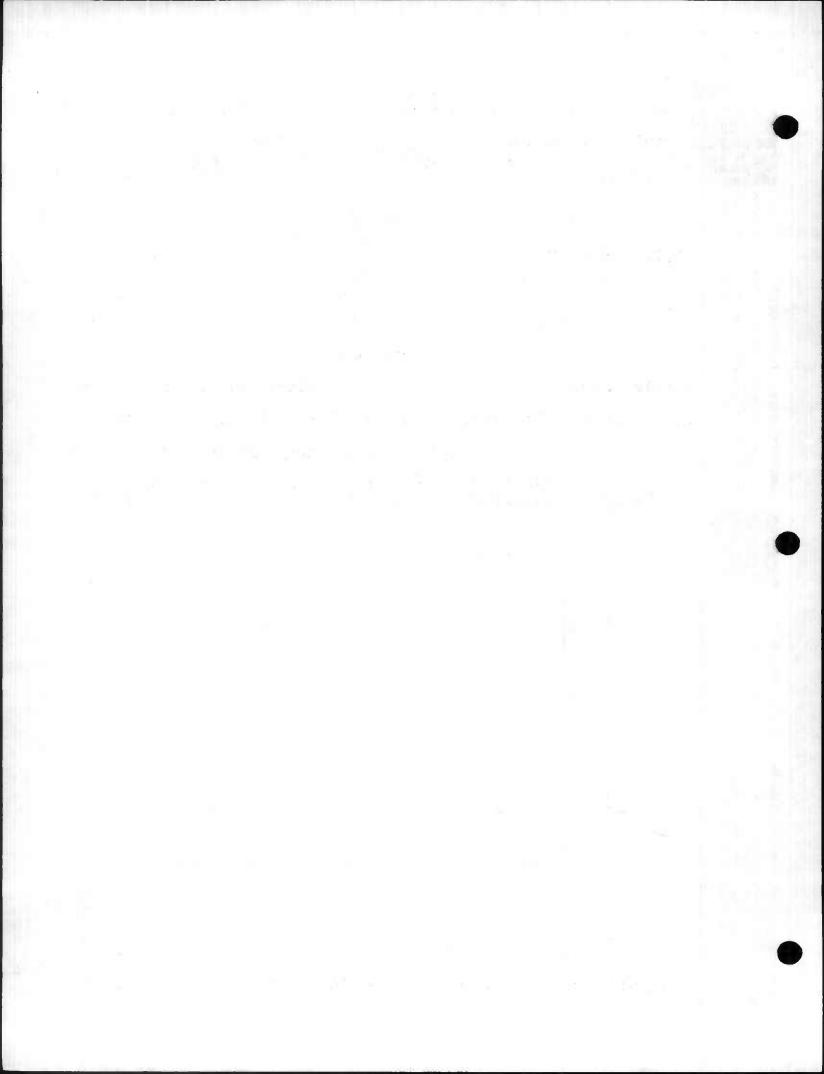
ARTHUR O. WOODDY, M.D. P.O. BOX 430 100 WAS H. AVE. LAPLATA, MD.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

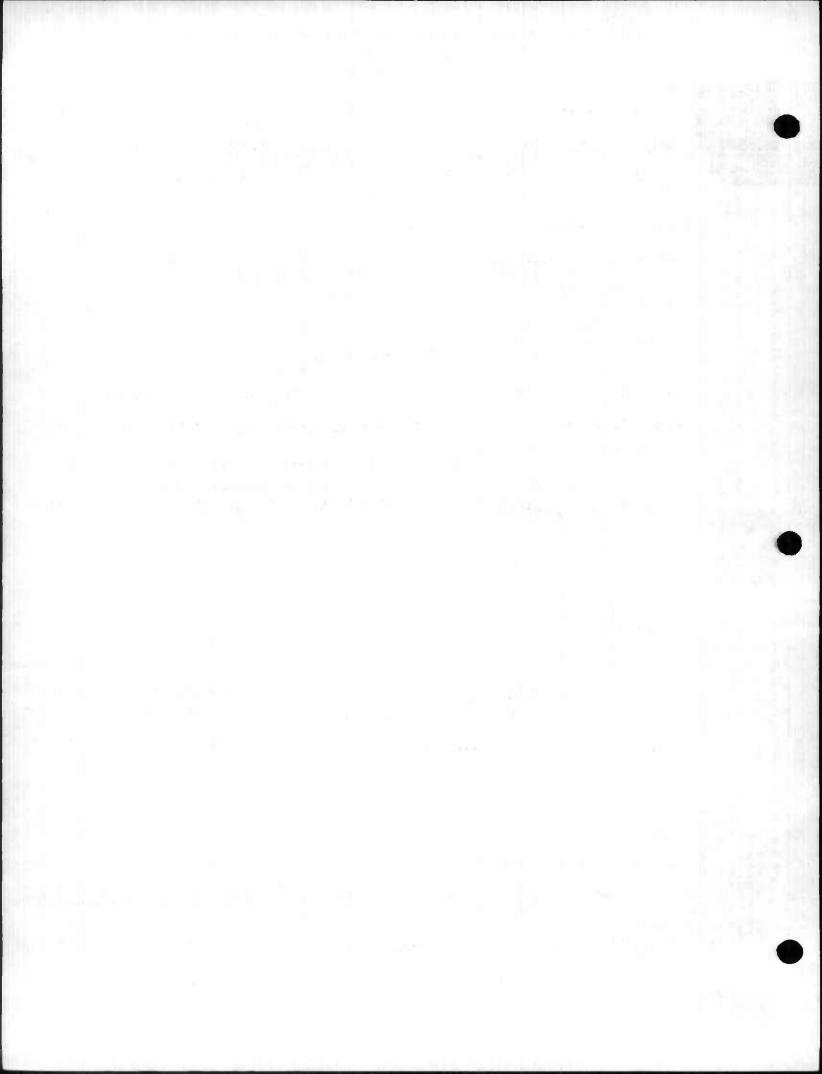
State Registrar

28e. Dete of Injury (Month, Dev Year)



State of Maryland / Department of Health and Mental Hygiene Q R

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/Medical Examiner Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consaquance of):	Approximate			
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The series of th				
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	available prior to completion of cause of death?			
To yes 20 No.				
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25. Wes casa referred to medical axaminar? 1				
8 2 7	cify)			
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29e. Certifier (Check only Madical Examiner: On the basts of examination end/or investigation, in my opinion, deeth occurred at the time, data and piece, end due to the cause(s) and manner as construction of the cause of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due	ural Route Number,			
28. Place of Injury - At homa, ferm, streat, factory, office building, atc. (Specify) 29c. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licansa number 28f. Location (Streat and Number or Ru City or Town, Stele) 28f. Location (Streat and Number or Ru City or Town, Stele) 28f. Location (Streat and Number or Ru City or Town, Stele) 28f. Location (Streat and Number or Ru City or Town, Stele) 29c. Letting (Specify) 29d. Certifier (Check only one) 29d. Signature and title of certifier 29d. Data signed (Month				
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D41931 May 15,	s steted. e to the ceuse(s)			
30 Name and address of person who completed cause of death (Itam 33a) (Type Print)	s steted. e to the ceuse(s)			
RShynecher MD 2309 Shorex'eld Ad Wheden M	s steled. to the couse(s) th, Day, Year)			
State 31. Dete filed (Month, Day, Year) 38. Begister's Signature And January - Rande Mana Jan	s steled. to the couse(s) th, Day, Year)			



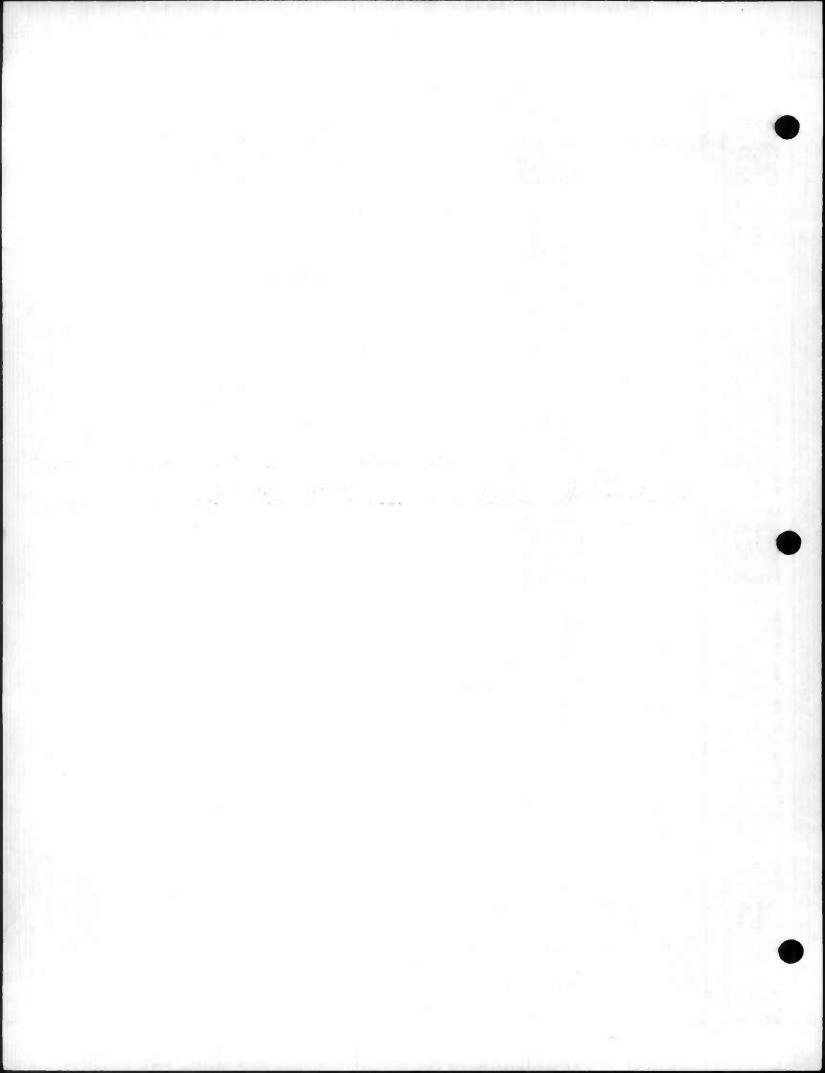
State of Maryland / Department of Health and Mental Hygiene

7069 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANNE GOLDEN KANTOR 2:00 pm 1998 /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Spaint SILVE B16 FONWICK (ANT MONTEOMERY 8. Date of Birth
July 2, 1911 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) New York C 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Min. 217-36-8704 86 Vrs York City Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d Inside City Limits traumatic event, the Medical Examiner rount be notified at Silver Spring 1 Yes 2 No Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 U.S.A. 20910 238 1316 Fenwick Lane Funeral items 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Healith and Mental Hygiene. Important: If Item 27 is marked other than "natural; or ite any Injury or other traumatic event, I'm Medeal Examing 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Tes 2 No specify: White by 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Institute Elementery/Secondery (0-12) College (1-4or 5+) of Health Biometrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jacob Golden Mindl Steinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul B. Kantor/Son 362 N. 4th Ave, Highland Park, N.J. 08904 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 R 4 Donetion 5 Qther (Specify) 3 Removal from State King David Mem. Gdns 5/20/98 Falls Church, VA 21. Signeture of Full and S 22. Name end Address of Facility any in Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or it failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicai CELEBRA UBSCULPA ARCIDENT Examiner Due to (or as a consequence of): HYDENTEWS IN Physician/Medical Examiner physician end tha burial-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury Due to (or es e consequence of): Box 68760; that initieted events resulting in deeth) Last Due to (or as a consequence of): 88 for use signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown UIABBIES MELLITUS þ 24b. Were autopsy findings evailable prior to completion of causa of deeth? 24e. Wes an autopsy performed? Completed s certificate has b director, page 2 s 1 Yes 20 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftar Naturel 5 Pending investigation 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated.

2 Ledical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29e. Certifier Medical completaly To the within 2 29b. Signatu nd title of certifier 29d. Date signed (Month, Day, Year) 01523L DME MAY DME MO. 40 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

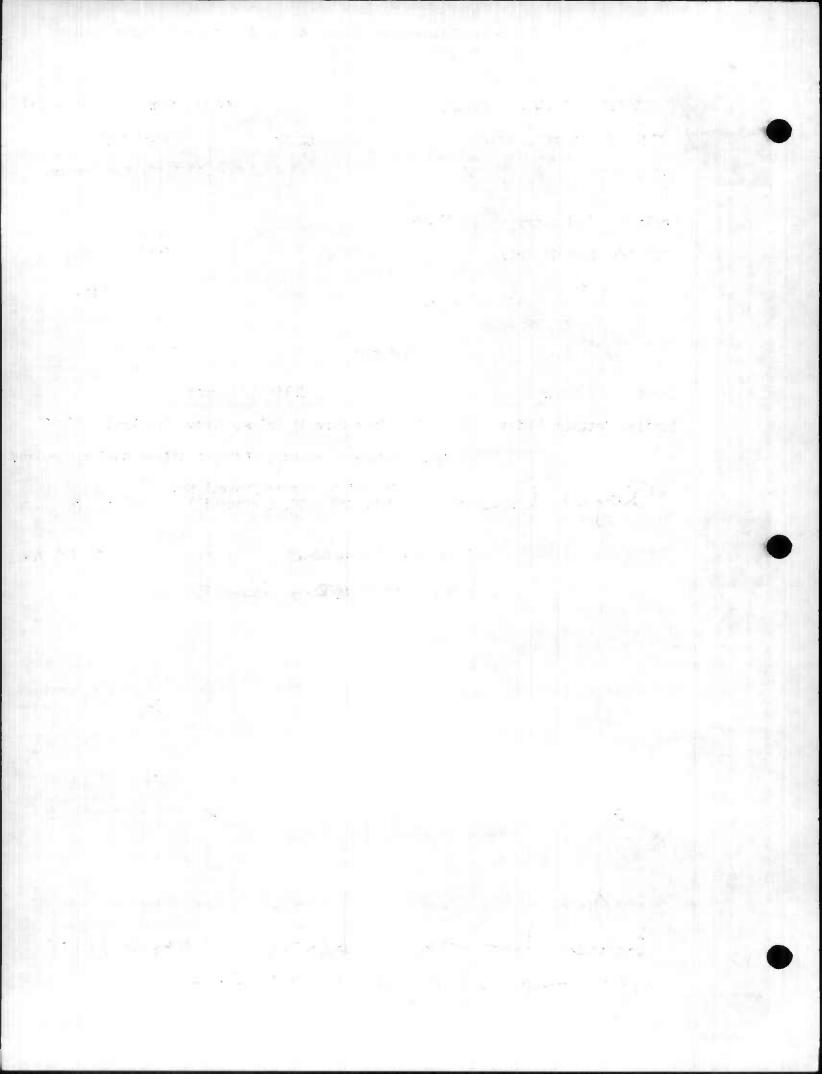
CHRLI. MARGOUS, MO. 1115 ROCKVIUS PIKE COCKVIUS, MD 20852 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAY 2 2 1998 Registrar

DHMH 16 Ray 6/95



		State of Maryland / Department of Health and Certificate of Death	Mental Hygle Reg.	000	7070
	Physician /Medical	RODERT EDWARD RASTNER		Day Yeer	13. Time of beath
	Examiner Funeral Director	45 City Town of	8. Dete of Birth	MONTGOMER 9. Birth County 933 New	
	how	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	vith the Marylan	Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code		. Citizen of What Cou	
020	urs efter death v al', or items 236 Examiner must	3/UI JONN CARROLL DRIVE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S. Armed Forces? 1 Married 12. Wes Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puer Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3		14. Race - Armer Black, White Specify: Wh	Ican Indian,
121215-0020	77 75 2 400	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 16e. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Engineer 18. Mother's Na	rking	b. Kind of Business/li Engineerin	Time and
aryland	should be marked o		. Byrnes		ip Code)
Baltimore, Maryland	00	Marilyn Kastner / Wife 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3701 John Carroll Driv cametery, cremetory or other plece) Gate of Heaven Cemetery	Date 20	c. Location - City or 1	
Balti	permit. Peg Department Important: if any Injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber F P.O. Box 5038, Lay 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or healt failure. List only one cause on each line.	uneral Hor	ne Maryland	20882
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardia shock, or healt disease or candition. fmmediate Cause (Finel disease or condition resulting in deeth) Due to (or as a consequence of): Let any, leading to immediate cause. Enter Underviving the cause. Enter Underviving the cause. Enter Underviving the cause. Enter Underviving the cause is the cause. Enter Underviving the cause. Enter Underviving the cause is the cause. Enter Underviving the cause is the cause of t			Approximete Interval Between Onset and Deeth
Box 68760,	physicies the burner of the bu	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of):			
P.O.	requires that the death certific seen signed by the attending a hould be detached for use as	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobe	1/-	to the cause of death?
ecords	> LI (0)		24a. Was an a	ed?	Vere autopsy findings syellable prior to completion of cause of death?
Vital R	certifican: rector	25. Wes case referred to medical examiner?	1 ☐ Yes	2 No 1	Yes 2 No
Division of Vital Records,	After fune		28d. Describe how	injury occurred	
			urred at the time, date	e and place, end due	to the cause(s)
	13	Isebelle M > 145014	H,	A 20 /	1998
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8379 CHERRY LAWE LAWEL IN REL IN RE	20707		
	State Registrar	The state of the s			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM #16 A PER MEO FILM G761 7-13-98 WR. Certificate of Death Amend #16a, 16b, 18, 5/28/98 BMW Morita, Co 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 6, 1998 **Physician DVEIRA** "DORA" KATOK 6:30AM /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, MAY 12, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐XF 92 Yrs. 341-62-3431 RUSSIA **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours eftar death with the Maryler nent of Heelth end Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or items 23s or 28s-1 show int: If Item 27 is marked other than "naturel", or other traumatic event, the Medical Examples must be nother as 1 Yes 2 □ No Director MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 263 CONGRESSIONAL LANE, #210 20852 USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, While, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes X☐ No Specify: Specify. þ 3 X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during the property of the property o 16b. Kind of Business/Industry Chemistry College (1-4or 5+) 5+ Elementary/Secondary (0-12) CHEMICAL ENGINEER 10 NONORGANIC CHEMICALS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MENDEL SORKIN Hana Minkina -UNODTATNABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEXANDER GRUZ / SON 263 CONGRESSIONAL LANE, #210, ROCKVILLE, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If eny Injury or 4 ☐ Donation 5 ☐ Other (Specify) MENORAH GARDENS 05/10/98 ROCKVILLE, MD 21. Signature of Funeral Sequent Licephee 22. Neme end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, DANIEL SIMONS Pert1. Enter the press, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or hear follows. Its only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MASSIVE INTERCRANIAL HEMORRAGE Examiner Due to (or es e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other algolificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed POLYCYTHEMIA VERA page 2 s 1 ☐ Yes 2 ☐ No HYPERCOAGUABLE STATE of Vital 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 papatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To DURIPA this funerai 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After or Attanding 1 Neturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigetion Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital within 24 hours a To the Funeral Completely filled Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end litle of certifier Centurymy D35791 05/06/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAY 1 8 1998

MERLYN VEMURY, 9801 GEORGIA AVE., SILVER SPRING, MD 20902

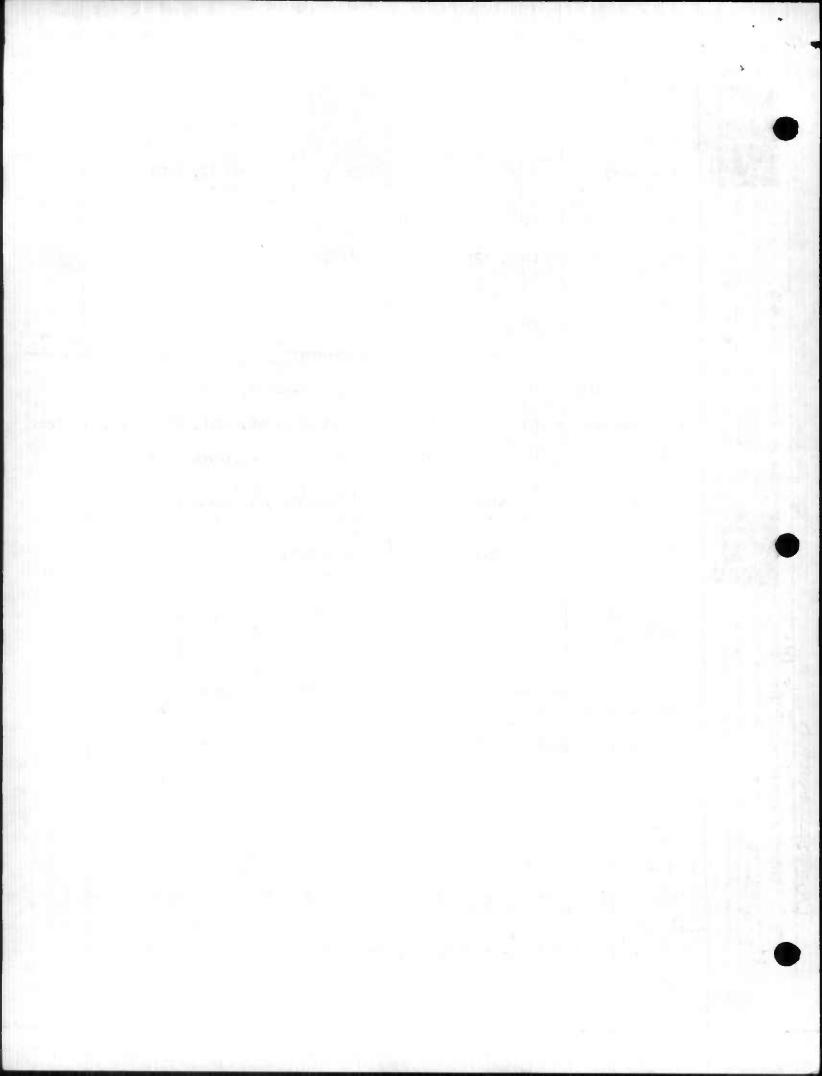
Julia Davidson-Randall

32 Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #4a,5/29/98, BMW, Montq. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** May 19° 1998 Beatrice Katz 4:45PM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11435 Monterrey Drive Silver Spring Montgomery 7. Age (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 8. Date of Birth
July 31,1926 New York **Funeral** Days 1 M 2 YE Hours 074-20-8483 71 Yrs. Director Usual Rasidence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mark be notified at 10d. Inside City Limits Maryland Montgomery 1 ☐ Yes 2 ☐ No Funeral Director Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11435 Monterrey Drive 20902 U.S.A. 12, Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 전 No if Yas, Give Year or Dates: Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Completed by 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic avant Elementary/Secondary (0-12) Coilege (1-4or 5+) U.S. Government Budget Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Israel Medwin Golda Sosonsky ပ 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Baume/Daughter 2811 N. Wentworth Tucson, AZ 85749 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Pernoval from State 4 Donation 5 Other (Specify) Lebanon Cemetery 5/22/98 Adelphi, MD 21. Signeture of Funeral Service 22. Name and Address of Facility Ives Pearson Funeral Home 22046 23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onsat and Death **Physician** dise se or condition resulting in death) /Medical lymphoca hieriths **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in daath) Last pue Due to (or as a consequence of) physician sthe buriel Physician/Medicai Due to (or as a consequence of): signed by the e Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitai: 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Natural 5 Pending death. 2 Accident Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 - Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: All completely tilled in by the fu

Medical

29a, Certifier (Check only one)

29b. Signature and title of certifier Matilda

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number

29d. Date signed (Month, Day, Year)

H. So, MD

D26250

30. Name and eddress of parson who completed cause of death (item 23a) (Type, Print)

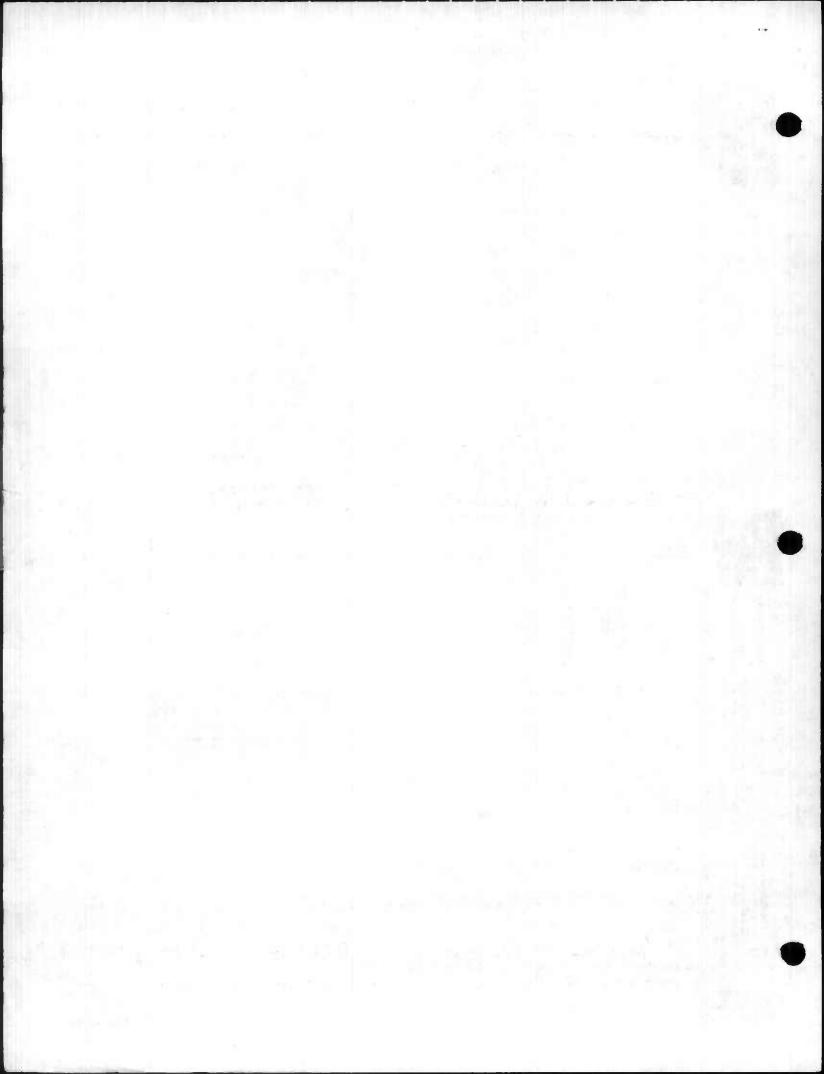
CONNECTICUT AVE, KENSINGTON, MD 20895 H. MATILDA 10810

31. Dete filed (Month, Day, Year) State

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32 Registrar'a Signature

Registrar



State of Maryland / Department of Health and Mental Hygiene 98

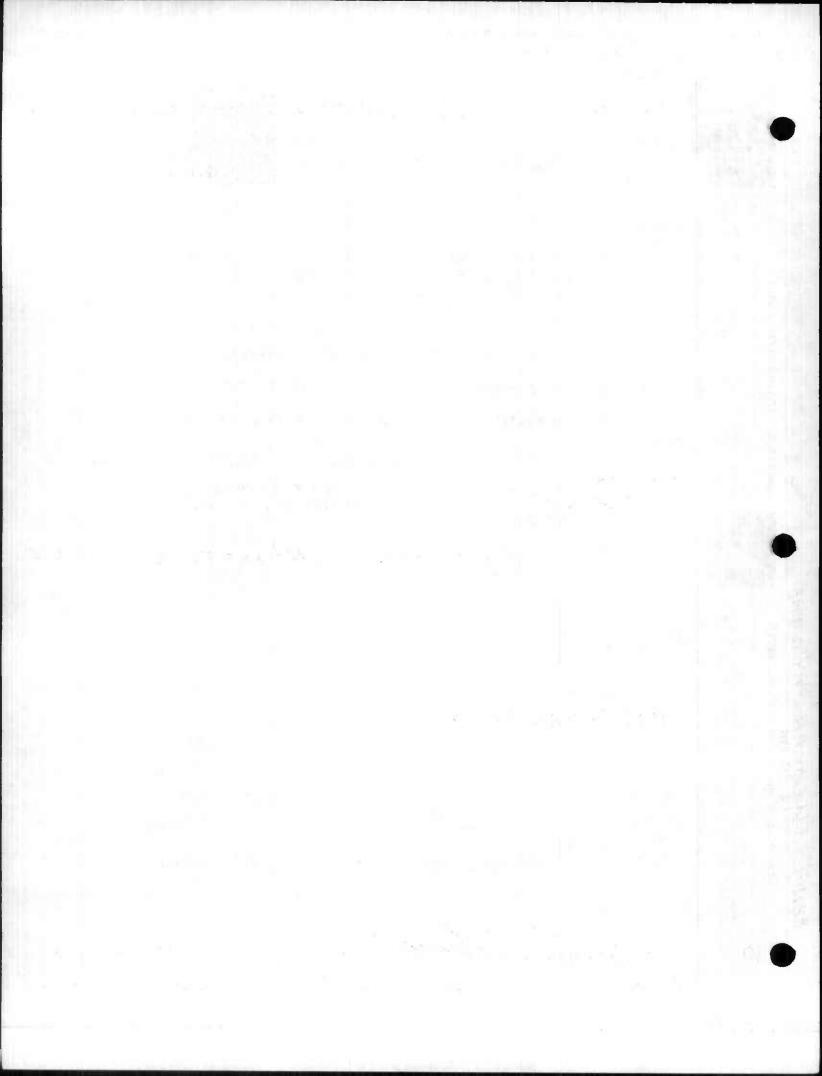
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E	Ö	2 # 5 E	Certification:	4 Homicide			bulk	ding, etc.	(Specify)						City or To	JWII, SIGI	Θ)		
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Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death KING Ma 2230 HR+HUR 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE el Security Number 6. Sex 7. Age (In yrs. lest birthdey) if Under 1 Yeer 1 if Under 24 Hrs. 8. MONTGOMERY 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Min. 10XM 2□ F Months Deys Hours Sept. 20, 1920 Ohio 274-18-8572 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 XYes 2 No Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 217 West Montgomery Avenue 20850 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ঐ Yes 2 □ No World If Yes, Give Year or Dates: War II Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: War II 3 Widowed 4 Divorcad White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Attorney Civil Law 18. Mother's Neme (First, Middle, Melden Surneme) 17. Fether's Neme (First, Middle, Last) Marion King Artie Kauffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Wilma R. King/Wife 217 West Montgomery Avenue, Rockville, MD 20850 20b. Place of Disposition (Neme of cemetery, cremetory or other place) MAy 22, 1998 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Fundral Service Licensee 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, MAryland 20850-2805 .M00803 Rockville, Maryland 20850-2 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Intervai Between Onset end Deeth Immediate Ceuse (Finei diseese or condition resulting in death) Due to (or es e consequence of): Paramon Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or es e consequenca of): 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? 1 Tes 2 VNo 1 Yes 2 No nlo 25. Wes case referred to medical exeminer? path 26. Piece of Deeth (Check only one) 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

item 27 is marked other than "natural", or flams 23a or 28a-f sho other traumatic avant, the Medical Examiner must be notified at

the Maryland

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Physician/Medical þ Completed Be

29e. Certifier

29b. Signeture end title of cartifier

Examiner sician and bunal-transit 10 Certification:

certificate be executed Box 68760. physician the 88 980 P.0. Division of Vital Records, certificate has this funeral ne Hospital or Attending Pl n 24 hours after death. After t

> State Registrar

filled in by

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Medicai

Hospital: 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piace, end due to the cause(s) and manner as stated.

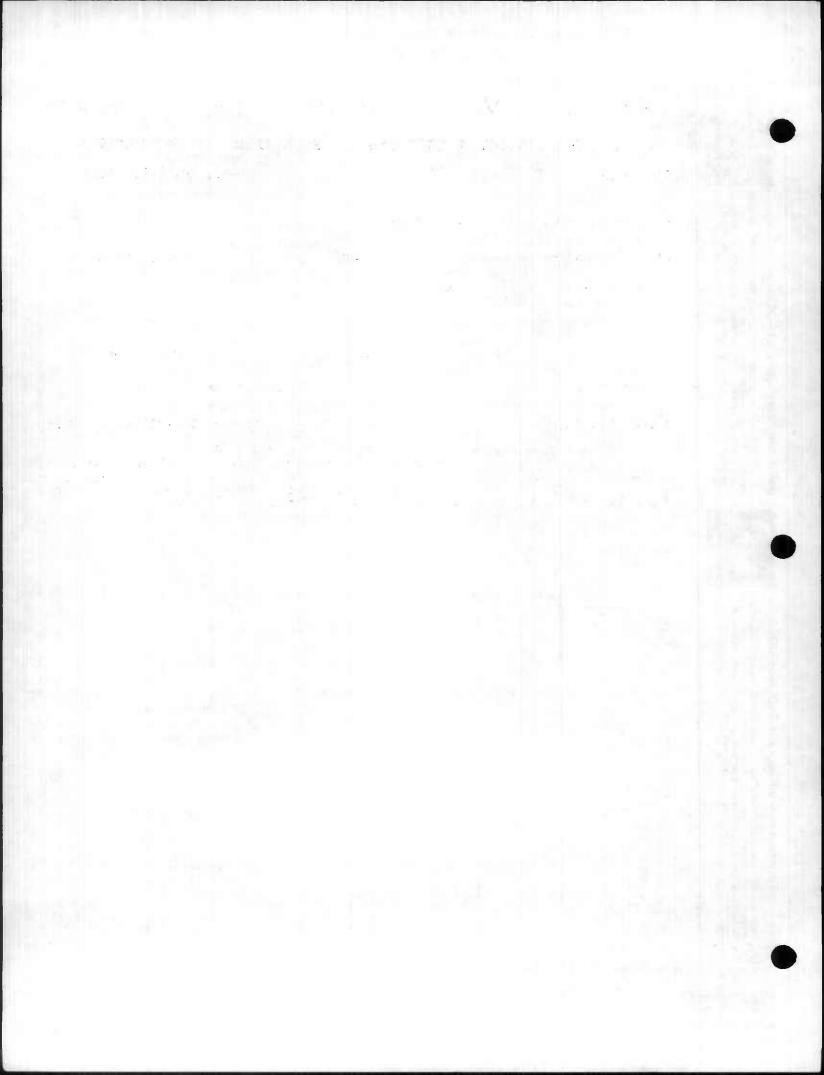
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and manner stated. (Check only one)

29c. License number 29d. Date signed (Month, Dev. Year)

nMO 031837

30. Name and address of person who completed cause of death (item 23e) (Type, Print) 615 WEST Buntord MD ROLLVILLE 10 Vmo 0850 31. Date filed (Month, Dey, Year) 32, Registrer's Signeture

MAY 2 2 1998 was Davidson-Ro



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #10e, 10f, 17, 18, 19b, 5/22/98, EMW, Montg. Co Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month Day **Physician** Syed Salar Kirmani 17, 1998 May 11:44 am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda, MD Montgomery If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral #M 2□ F 76 Yes 212-82-4120 Director India July 1, 1921 Usual Residence of Decedent 10a. Stete the Maryland 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or itema 23a or 28a-f ehow The Medical Examiner must be notified at 10b. County Montgomery Rockville 1 ☐ Yes 2 H No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11105 Wisper Wood Lane USA 20852 death Whisperwood 12. Was Decedent Ever in U,S. Armed Forces? 14. Reca - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus e filed within 72 hours after all Hygiena.

other than "naturel", or item 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Asian Indian ģ 3 ☐ Widowed 4 ☐ Divorced naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Engineer World Bank 18. Mother's Name (First, Middle, Meiden Surneme) Zalbunissa permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) Hanee Be Syed Haji Kirmani Zaibaniose Begum 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Whisperwood Lane Rockville, MD 20852 Zubaida Kirmani (Spouse) 11105 - 115 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 5-20-98 4 □ Donetion 5 □ Other (Specify) George Washington Cem. Adelphi MD 22. Name and Address of Fecility Hines-Rinaldi 11800 New Hampshire Ave. Silver Spring, MD 20904 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw Onset and Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Examiner ician and burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) physician the buria Physician/Medical Due to (or es e consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 50 à 24b. Were autopsy findings avelleble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed has certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending 12 Neturel death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attance within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 4 Homicide edicai Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

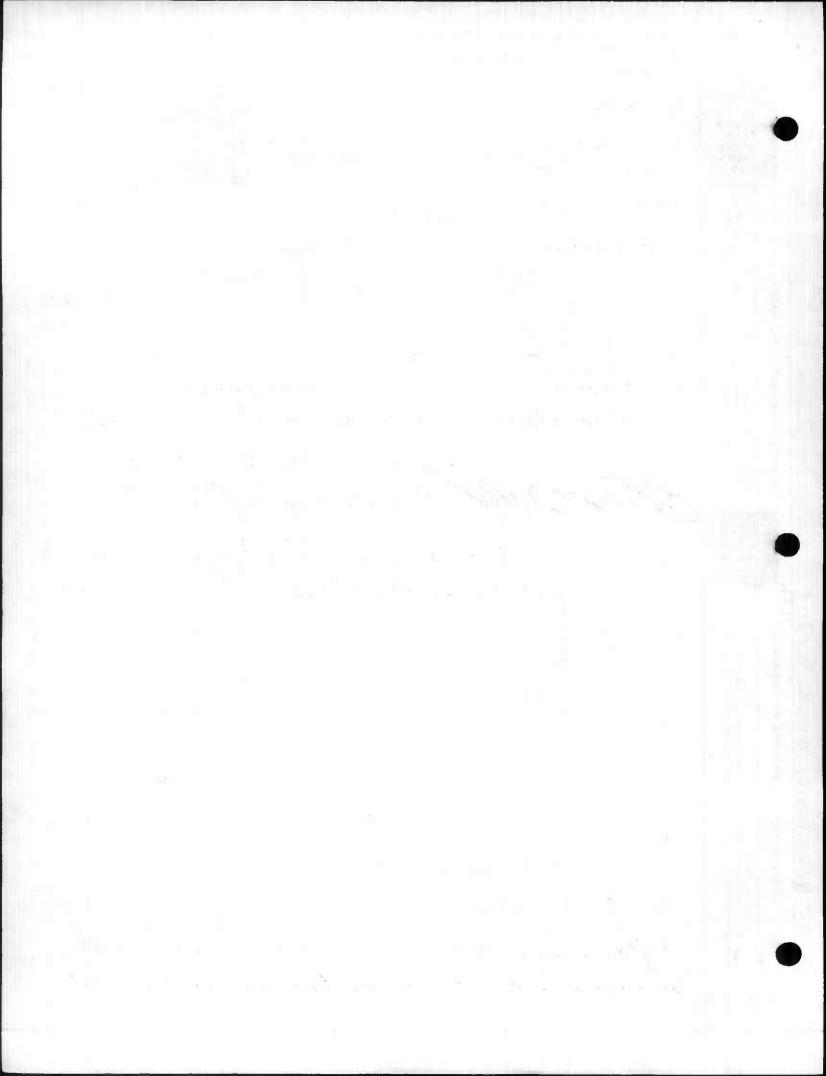
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner stated. 29e. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (VO 7056019 Neme end eddress of person who completed cause of death (Item 23e) (Typa, Print) 5454 Wisconsin for Charg Churc MD 20865 MENNER MERIS

32. Registrer's Signeture

State Registrar 31. Dete filed (Month, Dey, Yeer)

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						Ce	ertifica	ate of	Death		Reg. No.	18	17076		
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Examin	_	4e. Facility Neme	(If not institution, give	street and number)					4b. City, Town,	or Location of Dea		ty of Deeth			
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	Funeral Director	11. Marital Status		12. Wes Decedent Armed Forces?		J,S. 13.	Was Dec	cedent of I	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)			ican Indian,		
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d 2 should th and Men 7 is marke traumatic	Ĕ	Reuven Rosenblatt Ida Dressner 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)													
d2: th ar 7 is trau		Martin Klauber (son) 7603 Honesty Way, Bethesda, MD 20817													
T SE E		20a. Method of Dis		(SOII)	206.	Place of Disp	osition (A	lame of		Dele Dele	20c. Location		own, State		
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artmen ortant: injury	4	1	uneral Service Licen	_ /					ess of Facility	2 17 177	0 1501		10		
Dep		X	1	/ /			Dan	zansl	kv-Goldb	erg Memo	orial Ch	apel,	Inc		
-	-	23a, Part V Enter	he disease or com	dications that the en	the dee	eth. Do not en	117	O Ro	kville,	Pike, F	Rockv111	e, MI	20852		
)husisian		shock or hea	art failure. List only	one cause on each	90.						a,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	Interval Between Onsel and Deeth		
hysician /Medical		231. Part i Enter the disease, or complications that the best the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Gause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,													
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exec an en rial-tr	Exa	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease or	mmediate eriving		.0 (01 40 4 001100	,quoi ioo o	.,,.	I.K						
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ng ph as th	Med	resulting in death)	Last		,			,							
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law requires thet the death as been signed by the atter 2 should be detached for a	Severe aorter plevosis Aspustion Preumonia									24e. We	s an autopsy formed?	8	Vere autopsy findings vaileble prior to ompletion of cause f death?		
The lav ate has page 2	E O	/								1	Yes 2 No	1	Yes 2 No		
ysician: The s certificate director, pag	Be	25. Was case reference examiner?	rred to medical						26. Plece of E	Death (Check only	one)				
5 00	2	1 ☐ Yes 2 ☐	HNO	Hospitel: 1 Hospitel	ent 2	ER/Outpatie	ent 3⊡ l	DOA OI	her: 4 Nursing	g Home 5 ☐ Res	sidence 6 🗆 O	ther (Spec	ity)		
Attending Phir death.		27. Manner of Dea 1 ☑ Nelural 2 ☐ Accident	5 Pending	28a. Date of Inju (Month, Day	ry y Year)	28b. Time of Injury	Time of 28c. Injury at 28d. Describe t					how Injury occurred			
or Attendil efter death. Director: A J in by the fu	M 1 Vec 2 No										nber or Rui	ral Route Number,			

State Registrar

29b. Signeture and title of certifier

29a. Certifier

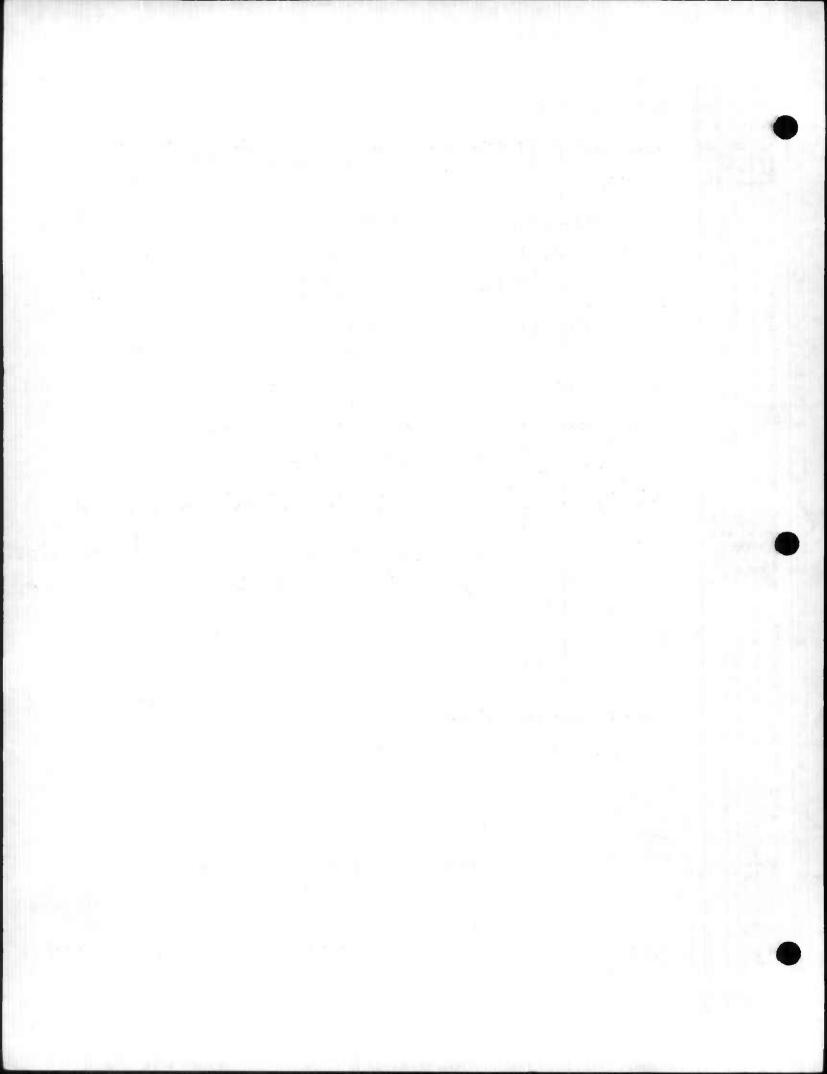
ROBERT GOLD - 15225 SHADY GROVE ROAD #201 - ROCKVILLE, MARYLAND 20850

aus

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month 1998 Year **Physician** 16, May Edward Charles Kolacz 7:30 PM /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 12913 Scarlet Oak Drive Gaithersburg Montgomery H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 4, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. 016-18-4387 84 1913 Massachusetts **Director** Usual Residence of Decedent the Manylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Medical Experience must be notified at 1 Yes 2 No Maryland | Montgomery Gaithersburg Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 12913 Scarlet Oak Drive United States deeth v Funerai 12. Was Decedent Ever In U.S. Armed Forces? 1 ∐XYes 2 □ No It Yes, Give Yeer or Detes: WW II Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours efter Hygiene. 1 Never Married 2 ☐ Merried 1 Yes 2 No by 3€XWidowed 4 □ Divorced White Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Electrical Contractor Construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Nem 27 Is marked oth any linjury or other treumetic svent BRGs. Karoline Penezar John Kolacz Stephan 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) JoAnn G. Blackler (daughter) Same as 10 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method ot Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donetlon 5 Other (Specify) 5-18-98 Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral Services, P. A. 21. Signeture of Funeral Service License Llen 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocardial Infarction 1 hour Examiner Due to (or es e consequence ot): Physician/Medical Examiner attending physician and for use es the bunal-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence ot): 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? the 6 1 Yas 2 No 3 Probably 4 Unknown Status post Aortic Valve Replacement Division of Vital Records, þ 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to Completed Peptic Ulcer Disease completion of cause of death? has 1 Yes 2 No 1 Yes 20 No certificate or Attanding Physician: 25. Was case reterred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: 1□ Yes 2N No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this n 24 hours after death.

Ne Funeral Director: After this pletely filled in by the funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 10 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) To the I within 2 To the I 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D 31839 May 18, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 West Montgomery Avenue, Rockville, MD

State Registrar Christopher C. Dunford, M. D.,

MAY 1 9 1998

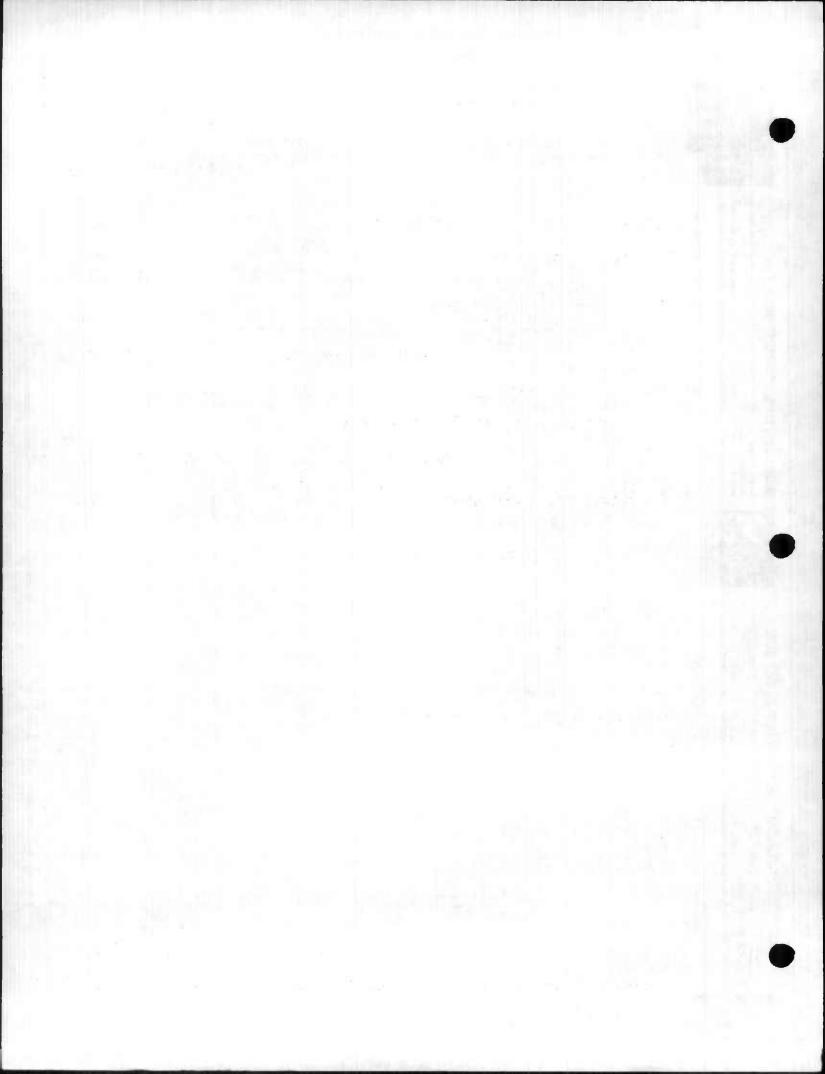
32, Registrar's Signature

while Davidson-Randalle

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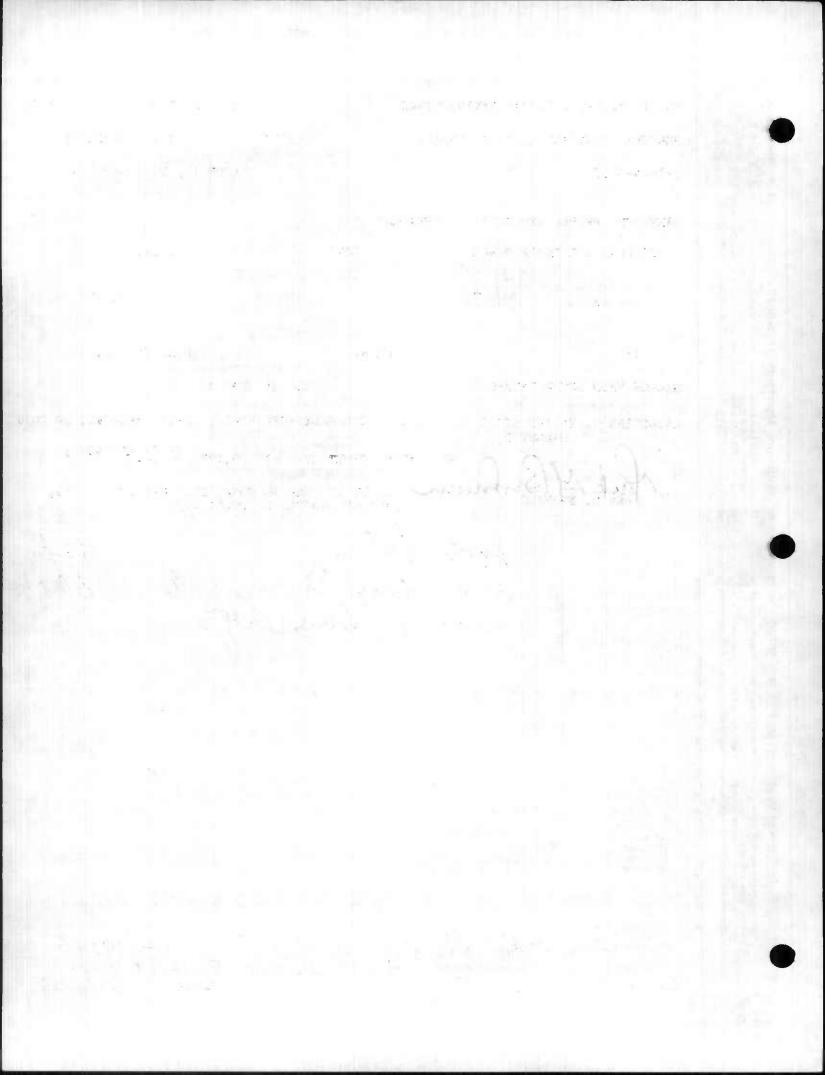
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			Certificate of L			eg. No. 9 8	3 1	7078							
	Physici /Medio		Decedent's Name (First, Middle, Last) NELLIE TAYMAN CELESTIA KALIVRETENOS		2. Data of Dea Month MAY 18	Day	Year	3. Time of Death 3:25 AM							
8	Examir		4a Facility Name (If not institution, give street and number) 4	lb. City, Town, or L	ocation of Death	4c. County of									
				CLINTON		PRINCE									
	Funeral Director		5. Social Sacurity Number 6. Sax 1 M 2 F 7. Age (In yrs. last birthday) Yrs. 1 North Days	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey MARCH 14	Year) 1921	9. Birthple Count MARY	ace (State or Foreign try) LAND							
	pue M		Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location				10	Od. Inside City Limits							
ter death with the Marylen frems 23a or 28a-f show ther mat be notified at		to	MARYLAND PRINCE GEORGE'S UPPER MARLBORO					1 ☐ Yes 2 No							
		Director	10e. Street and Number 10f. Zip Code		1	0g. Citizen of W	nat Country?								
			13523 LORD BALTIMORE PLACE 20772		U.S.A. 7 (Specify Yes or No-										
15-0020 in 72 hours of "natural", or	urs efter dea st', or flems Examiner m	To Be Completed by Funeral	11. Marital Status 1 Never Married 1 Never Married 3 Widowed 1 Never Married 1 Yes, Give Year or Dates: 1 Never in U,S. Armed Forces? 1 Never in U,S. If Yes, specify Cubar 1 Yes, Sive Year or Dates:	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	en Indian, atc. TE									
	72 ho		15. Decedent's Education 16a. Decedent's Usuel Occups (Specify only highest grade completed) (Give kind of work done d	ation during most of work	working 16b. Kind of Business/Industry										
	within lene. then "		Elementary/Secondary (0-12) College (1-4or 5+) lifa. DO NOT use retired)	0	U.S. POST OFFICE										
	Hygier the the the		11 CLERK 17. Father's Name (First, Middle, Last)	18 Mother's Nan				FICE							
and	S E D		GEORGE WASHINGTON TAYMAN		Name (First, Middle, Meidan Sumema) Y TAYMAN										
Maryland	2 should and Men is marke surratic		19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street e			, City or Town,	State, Zip	Code)							
Ma	d d d d d d d d d d d d d d d d d d d		CATHERINE L. KALIVRETENOS 13523 LORD BAI												
Baltimore,	Pages 1 an nent of Heal nt: If Item 2 iry or other		20a. Method of Disposition DAUGHTER Buria 2 Cremation 3 Removal from State	1	Date 20, 1009		MARLB								
altin	구투분증		Buria 2 Cremation 3 Removal from State MT. CARMEL CEMETERY MAY 20,1998 UPPER MARLBORO, MARYLAND 22. Name and Address of Facility THE HUNTT FUNERAL HOME, POST OFFICE BOX 156,												
m	Depariment of the pariment of		JHK MARK G. BROHAWN THE HUNTT H	FUNERAL H	HOME, PO	ST OFFIC	E BO	X 156,							
	Dhualalan		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying shock, or heart feilure. List only one ceuse on each line.	g, such as cerdiac	20604-0 or respiratory ari	est,		Approximate Interval Between Onset and Death							
	Physician /Medical		Immediate Cause (Final					77h							
	Examiner		disease or condition resulting in death) Due to (or as a consequence of):	7,		11		1							
-	D 15	luer	Due to (or as a consequence of):												
	icate be executed physician and sthe buriel-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	conditions, Due to (or es a consequence of):											
68760,	physician at the buriel	<u>e</u>	Ceuse (Disease or Injury	9/1	U)										
687	No. 270, 441	edical	resulting in death) Last Due to (or as a consequence of):												
Box	death certific e attending p ed for use as	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the conditions conditions contribute to the conditions													
	0 0 0	sicle	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse give	en in Part I.	23b. Did t	obacco use con	itribute to	the causs of death?							
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IS,	signed d be del	by			04-144		245 W	ere autopsy findings							
Vital Records,	v require been si should	Completed			24a. Was a	med?	ava	ailable prior to mpletion of cause							
Rec	hes hes	dE.				1		death?							
a	Ician: The L certificate he rector, page		OF West and the second		1 D Y		11	JYes 2□No							
		o Be	25. Was case referred to medicel axaminer? 1 Yes 2 No Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other	er.	eth (Check only o		as /Canadi	L.I							
of		-	27. Manper of Death 28e. Dete of Injury 28b. Time of 28c. Injury		lome 5 ☐ Resid			77							
ion	Attending For death.	atlo		Yes 2 □ No											
Division	or Attendate death Director: /	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (S City or Tow		er or Aure	el Route Number,							
Ö	ital or ital or ital or ital or ital	S	and grant (option)												
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b	edical	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, death occurred at the tim (Check only one) 2□ Medical Examiner: On the basis of examination and/or investigation, in my or end menner stated.												
	o the	2		e number	_	9d. Date signed	sfeMonth.	Day, Year)							
	m > m 0		en 2m2 MD Attending In-	2453	5	51	19	198							
		Ì	30. Name and address of person who completed cause of deeth (Item 23a) (Type Print) 77% Old Bo and b AUR.												
			LAXMI BERUA M.D. C-1	101 6	Into	U, M	1).	20735							
	Sta		31. Date filed (Month, Dey, Year) 32. Registra's Signature MAY 2, 2, 1998 July Davidson Revolution												
	Registr	ar	MAI 6 6 1330 Jane was to the												



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month C CONNIE SUE KOENIG 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death SINAL HOSPITAL BALTIMORE TIMORE CIT 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1 M 2 KF Months Days Hours 214-68-0845 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Westminster Carroll 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Singer Drive 1120 21157 United States 12. Was Decedent Ever in U,S. Amed Forces? 1 ☐ Yes 2 No if Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Stetus Rece - American Indian Bieck, White, etc. 2 Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) Dental Technician Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joseph James Card, Jr. 19a. Informent's Name/Relationship (Type, Print) Lottic Harc 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pamela Hargrove, sister 703 Grand Valley Court Westminster, MD 21158 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Pritts, Funeral Hone & Chapel 412 Washing Ton Road 5-18-98 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23e. Pert1. Enter the disease, or complications that caused the fields. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Deeth immediate Cause (Final disease or condition resulting in deeth) MUDGARDIAL INFARCTION WEEK DRONALLI ALTENY DISTABE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) I est

Physician /Medical **Examiner**

Physician

Examiner

Funeral Director

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Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, ma Medical Examiner must be notified and

Baltimore, Maryland 21215-0020

/Medical

Hospital or Attending Physician: The law requires thet the death certificate be executed Z4 hours effer death.

Evental Director: After this certificate has been signed by the attending physician end thereis Director: After this certificate has been signed by the attending physician end seley filled in by the funderal director, page 2 should be deteched for use as the burlet-transit

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Division of Vital Records, P.O. Box 68760.

Tesuming in death) Lest	d			V	
Pert II. Other significant conditions of	ontributing to death but not res	sulting in the underlying caus	se given in Part I.	23b. Did tobacco use co	ntribute to the cause of death?
				24a. Was en eutopsy performed?	24b. Were sutopsy findings available prior to completion of ceuse of deeth? 1 Yes 2 No
25. Was cese referred to medical examiner?			26. Place of De	eth (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specity)
27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day Year)	28b. Time of Injury M	Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, of	ffice	28f. Location (Street end Numb City or Town, Stete)	per or Rurel Route Number,
29a. Certifier (Check only one) 12 Certifying Ph	yalclan: To the best of my knowniner: On the besis of examine end manner steted.	owledge, death occurred et ti etion end/or investigetion, in	he time, date and plac my opinion, death occ	e, end due to the ceuse(s) end ma urred at the time, dete and place,	anner as stated. and due to the cause(s)
29b. Signature end title of certifier		29c.11	cense number	29d Date signe	d (Month Dev Yeer)

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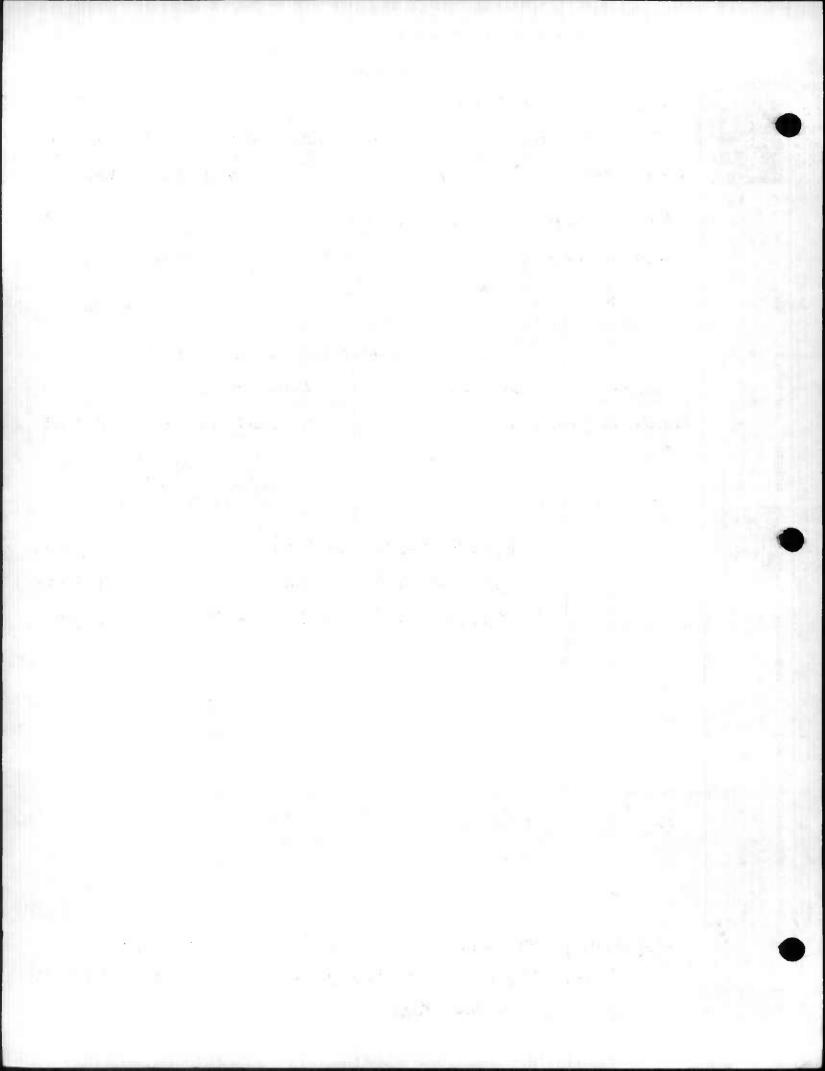
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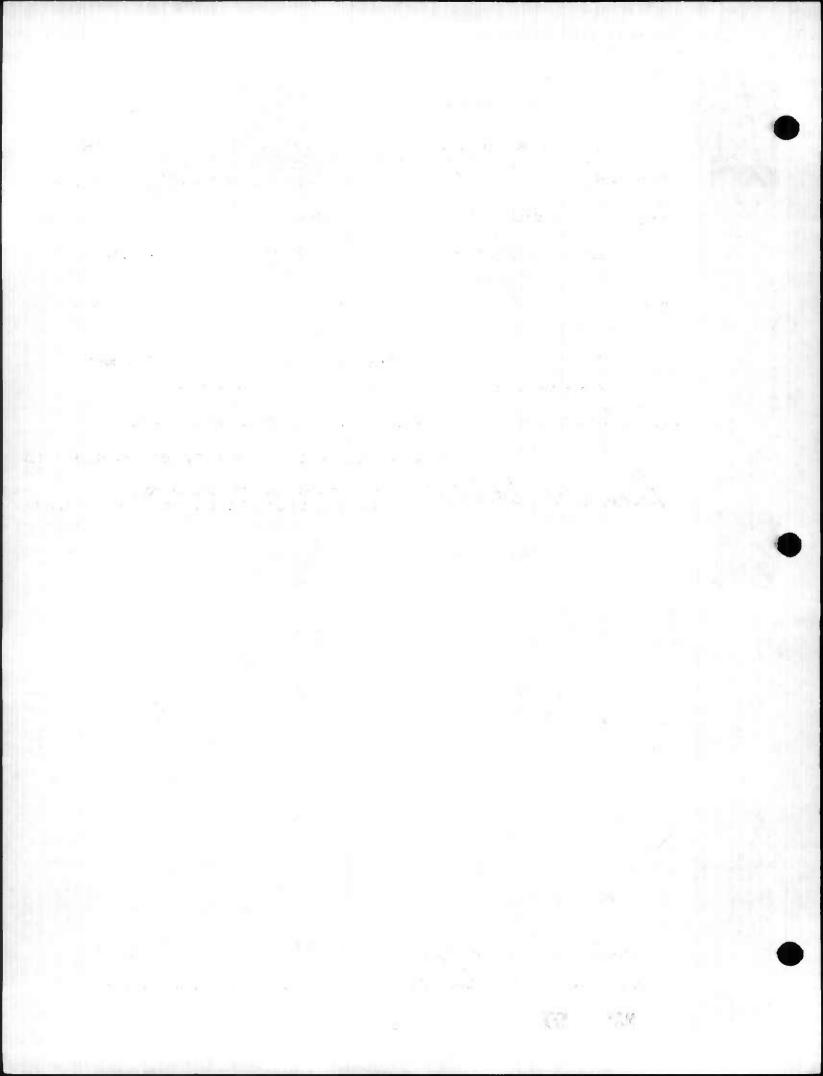
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ed cause of death (Item 23e) (Type, Print)

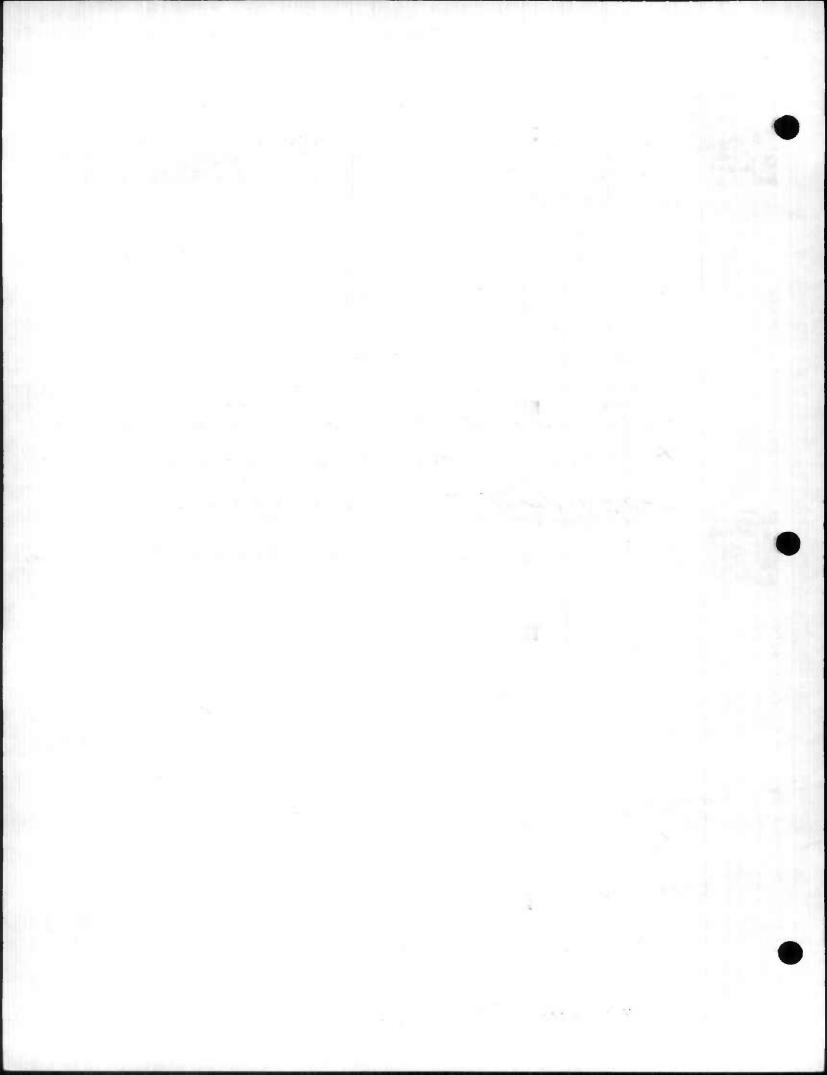
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	Physic /Medi			izabeth	n KORR			2. Dete of Deal Month May	Day	1998 12:03			
	Examir	ner	4a. Fecility Name (If not institution, giva street end numb	per)		- 1	4b. City, Town, o	r Location of Death	4c. County				
			Citizens Nursin	ng Home	9		Fred	erick		lerick			
	Funeral		5. Social Security Number 6. Sex 7.	. Aga (In yrs. I	lest birthdey) If L	Inder 1 Year	if Under 24 H	s. 8. Date of Birth	Vacal		aca (State or Foreign		
	Director		216-54-8166	97	Yrs.	nths Days	Hours Mi	May 20,					
	D		Usuel Rasidence of Decedent					11111 201	1500		- IML J LUIM		
	Merylar f show	Jo.	10a. State 10b. County Maryland Frederick	10c. City	y, Town or Location		cederick			10	d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	the l	90	10e. Street and Number		10	f. Zip Code			0g. Citizan of 1	Affront County	-0		
	E O E	ō	8630-A Indian Springs	Poad	10	i. Zip Code	21702	1.		S.A.	ry r		
	23	era											
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any folyury or other traumatic event, the Medical Exeminer must be notified at once.	by Funeral Director	11. Maritei Status 1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give Year or Date	as? No		specify Cub	fispanic Origin? (an, Maxican, Pue Specify:	(Specify Yas or No- rto Ricen, etc.)		ce - Americe ck, White, a			
ō	2 ho		15. Decedent's Education		16a. Decedent's	Usual Occur	pation		16b. Kind of B	usiness/Indu	ustry		
7	n'n	Die	(Specify only highest grade completed)		(Give kind o	of work done OT use retire	during most of w	orking			,		
7	with iene.	Completed	Elementary/Secondary (0-12) Collega (1-4	or 5+)									
	be filed within ital Hygiene. d other than event, the Me		17. Fether's Nama (First, Middle, Last)		Home	maker-	18. Mother's N	ame (First, Middle, M		m Hom	е		
an	Mental Mental arked o	Be	Fleet Eugene Nu	100						,			
Maryland	should nd Mer merke umerke	T _o		ise				Sophie St					
Z Z	12 shows a second resummers		19a. Informant's Name/Ralationship (Type, Print) Betty E. Wiles/Daughter		19b. Mailing Add		Code)						
	1 and Health ern 27 other tr			Tan a			Lane, r	rederick,					
0	of H		20a. Method of Disposition 1	ato C6	lace of Disposition emetery, cramatory	or other ple			20c. Location -				
E	Pages nent of I nnt: if ite ury or o		4 Donetlon 5 □Other (Specify)	Res	sthaven M	emoria	1 Garde	ns May 19	, 1998	Fred	erick, MD		
Baltimore,	permit. Page Depertment Important: if eny injury or once.	0 0	21. Signature of Funeral Service Licenses	ne									
	Physician /Medical Examiner		23a. Part 1. Entar tha diseese, or complications that such shock, or heart failura. List only one causa on each immediate Cause (Final disaasa or condition resulting in death)	statio	Do not entar the	mode of dylr	ng, such as cardi	h Street, ac or respiretory arm	rreder		Approximata Interval Betwaan Onset and Death MGJ		
_	P #	Iner		Dua to (or	r as a consequance	9 of):							
,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be deteched for use as the bunal-trensit	Examiner	Sequentially list conditions, if any, laeding to Immediata ceuse. Enter Underlying	Dua to (or	as e consequance	of):							
8760,	sicla bun	dical	Cause (Disaasa or Injury that Initiated events	Due to to	200 - 101 - 100 2	- 0							
Φ	tificate ng phy es the	w	resulting in death) Last	Dua to (or	as a consequance	01):							
Box	that the death certifi ed by the attending detached for use es	Physician/M	d			_							
0	deatl	icia	Part II. Other algolificant conditions contributing to deat	h but not recu	illing in the underly	ing course of	on in Dart I	22h Did to	hanno uma no	ntelbute to t	the cause of death?		
o.	the try the	hys			ining in the underly	ing ceuse giv	en in Part I.		_ _/				
S, P	es that igned b	by P	Diapter Melli	· U/				1 🗆 Y	2 2 No	3 Probi	ably 4 Unknown		
g	sign d be		Diabter Mallit					24a. Was e	outone.	24h Wer	e autopsy findings		
Record	v requir been s should	Completed	Hypertendin					perform		evai	labla prior to		
ě	has I	Idu								of de	eath?		
		S						1 □ Ye	s NO	10	Yes 2□ No		
=======================================	ician: The certificate rector, pag	Be	25. Was cese raferred to medical axaminer?				26. Place of De	eath (Check only on	a)	1			
=	Physician: this certific al director,	2	1 Yes 25 No Hospital: 1 ☐ Inp.	atient 2 E	ER/Outpatient 3E	DOA Oth	er: Wursing	Home 5 ☐ Reside	nce 6 Oth	er (Specify)			
0			27. Mannar of Death 28e. Data of I	njury Day Year)	28b. Tima of Injury	28c. Injur Wor		28d. Dascribe ho					
0	ath. :: Aft	atio	1 Naturel 5 Pending (Month. 2 Accidant Investigation	Day (bai)	М		Yes 2 □ No						
Division of Vital	To the Hospital or Attending Physician: which 24 hours lifer death. To the Funeral Director After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 8 ☐ Could not be determined 28e. Place of	Injury - At hor, atc. (Spacify)	me, farm, streat, fa	ctory, office		28f. Location (St. City or Town	reet end Numb , State)	per or Rural	Routa Number,		
	To the Hospital or within 24 hours effective the Funeral Dir. completely filled in	edicai (
	ofth ofth ompl	M	29b. Signature end title of certifier			29c. Licens	e number	26	d. Data signe	d (Month. D	av. Year)		
	⊢≯Fŏ		▶ C. ★· D	1460			9689		_ /		.,		
7			Justin Jear	1-7		10:			211	03 0	18		
		30. Name and address of person who completed ceuse of daarf (Itom 23a) (Typa, Print)											
			Austin Pearre, Jr.,	M.D.	300 West	Nint	n Street	, Frederi	ck, MD	21701	L		
	Sta Registr			istrar's Signet	ura								



				State of Mar		rtificate of			Reg. No.	8	17081				
	nysici:		Decedent's Name (First, Middle, La MARY	LEEE	KE	NDRICK		2. Data of Dec Month May 13	Day	Year	3. Time of Death 1:20 A.M.				
	Medic kamin		4a. Facility Name (If not institution, give		70.	MERCIC	4b. City, Town, or	Location of Death							
			Glade Valley Nu	rsing Home			Walkers	ville	Fred	rederick					
Fur	neral				(In yrs. last birthday)	If Under 1 Yaar	If Undar 24 Hrs	8. Date of Birt			lece (State or Foreign				
	ector		405-12-5973	1□M 2 X F	85 Yrs.	Months Days	Hours Min	Jan. 1	0, 1913		tucky				
and	**		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Lo	ecation				1	0d. Inside City Limits				
Mary	i pag	tor	Md. Freder	· ck	Frede	riole			1 ☐ Yes 2 ☐ No						
the 28s	not	Director	10e. Street and Number		ricae	10f. Zip Code			10g. Citlzen of V	Vhet Coun	Country?				
h with	ti di		1700 Algonquin	Rd.		2170	01		United	ed States					
deat	r D	Funeral	11. Marital Status	12. Was Decedent Everage Armed Forces?	er in U,S. 13.	Was Decedent of I	Hispanic Origin? (S	Specify Yas or No-	14. Race	ce - American Indian, ack, White, etc.					
5-0020 72 hours after death with the Maryland	the Medical Examiner must be notified at		T⊠ Nevar Married 2 Married	1 Yes 2 No		1 ☐ Yes 2 ☑ No		10 1 110411, 010.7	Specify						
Nours Pours	I Ex	d by	3 Widowed 4 Divorced	Yaar or Dates:					ite						
727	adica	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wa	orking	dustry						
Maryiand 21215-0020 ad 2 should be filed within 72 hours aff tilth and Mental Hygiene.	Na M	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	0)								
belied by the property of the	PIT, I		7th 17. Fathar's Name (First, Middle, Last)	пош	emaker	18. Mother's Na	me (First, Middle,	own home						
yian buid be Mental	C .	To Be	Thomas Hans	ford Kendr	ick		Ann Mc	Kecknie							
Tarylar 2 should b and Mente	Tampa Tampa		19a. Informent's Neme/Relationship (Type, Print)	19b. Mailin	ng Address (Street	end Number or R	Tural Route Numbe	er, City or Town,	State, Zip	Code)				
1 and 2 Health a	=		Anna Laney Seirs	dale/grandd	in Rd./	Frederic	k, Maryl	and	21701						
Saltimore, Semit. Pages 1 ar Department of Hea	oth		20a. Method of Disposition		20b. Piace of Dispo			Date	20c. Location -		wn, State				
Page Page	ILY OI							5-16-98	Montice	110.	Kentucky				
Description of Heal	any Inju		Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Elksprings Cemetery 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md. 21702												
D 88 E	# g														
			23a. Part1. Entry the disease, or com- shock, or heart failure. List only	plications that caused th	e death. Do not ent	er the mode of dyl	ng, such as cardia	c or respiratory ar	rest,	rid.	Approximate Intervel Between				
Physi	cian									1	Onset and Death				
/Med Exam			Immediate Cause (Finel disaase or condition	a. Chron	ic Of	s thuc	the P	ulmon.	Lon Pu	ene	54 cari				
LAGIII	mei		resulting In death)		ue to (or as a consec		•								
Pe	sit	ulu		b. ————						1					
icate be executed physician and	s the burial-transit	Sequentially list conditions, if any, leading to immediate figure and the cause. Enter Underlying and the cause. Enter Underlying and the cause.													
ficate be ex	buri														
ficate	s the	edic	Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of):												
box attending	detached for use a	2		d											
death	d for	Physician/M	Part II. Other significant conditions of	contributing to death but a	not resulting in the u	nderlying cause gi	ven in Part I	23h Did t	obacco usa cor	atribute to	the cause of death?				
that the d	ache	hys	Tartin other significant conditions of	ontributing to death out i	not resulting in the d	noonying cause gr	ven in ranti.		Yes 2 No		pably 4 □ Unknown				
s that	pe del	by P													
requires been sign	should							24a. Was	an autopsy		ere autopsy findings alleble prior to				
e law re	2 sh	Completed						20.00		100	mpletion of causa death?				
T He de	page	МО						101	res 20 No	10	Yes 22 No				
VICIAN: The	ctor,	Be	25. Was case referred to medical axaminer?				26. Place of De	eath (Check only o	ne)						
OI VICAL MECOTOS, Physician: The law requires t this certificate has been signe	=	ို	1 Yes 2 No	Hospitel: 1 ☐ Inpatient	2 ER/Outpatier	I 3 DOA		Home 5 Resid	dence 6 □Oth	ar (Specif)	0				
	nuera	on:	27. Manner of Death 1. ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(aar) 28b. Time of Injury	Wo		28d. Describe h	now injury occurr	ed					
i or Attending after death. Director: After	the f	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b				Yes 2 No	2011			10				
or Attending after death.	in by	ertification:	4 ☐ Homicide determined		r - At home, farm, str (Specify)	eet, factory, offica		City or Tox	Street and Numb vn, State)	er or Hura	I Houfa Number,				
Hospital 24 hours a Funeral D	completely filled in by the funer	O	29a, Certifier 17 Certifying Ph	welclan: To the best of	my knowledge de-41	nonurrad at the ti	me data and also	e and due to the	neuse/s) and s	nner ee c	bated				
the Hospital hin 24 hours the Funeral	letely	edical		nysician: To the best of r niner: On the basis of ex and manner state	caminetion and/or in										
To the within 2	dwo	≥ 29b. Signature and title of cartiflar 29c. License number 29d. Date signed (Mc									Day, Year)				
- 4 2 -1	0	Michael Lerner M.D D41619 May 13, 19									198				
			30. Neme end eddress of person who	completed cause of deel	, ,	Print)			-						
			Michael Lerner, M.D. / Frederick St./ Walkersville, Maryland 21793												
	Stat	te	31. Date filed (Month, Day, Year)	32 Benietraria	Signature		HGTKEL	OVELLE'S	INT Y Late	u _	173				
Re	gistra	ar	MAY 1 4 19	998 Alia Savides Revelet											
					-	1000									



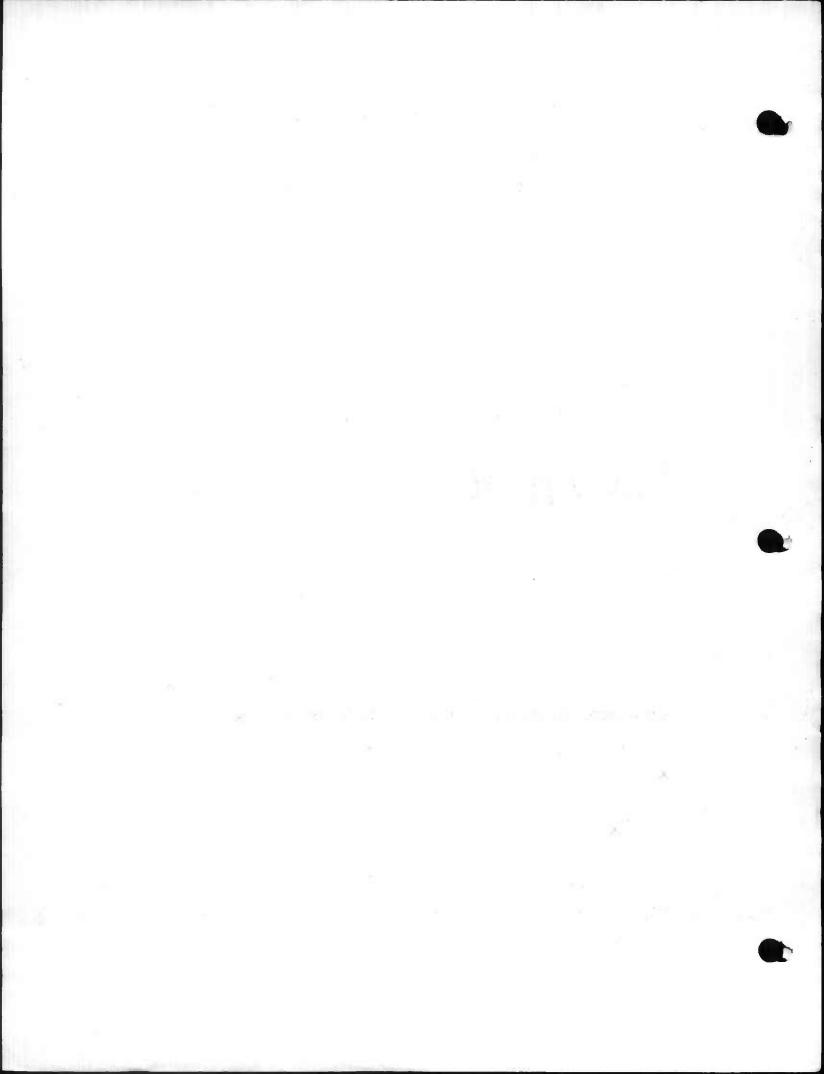
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed witthin a hours after death. Page 6 may be retained by the hospital or attending physician.	er death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should rel.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	I examiner must be notified at once.
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

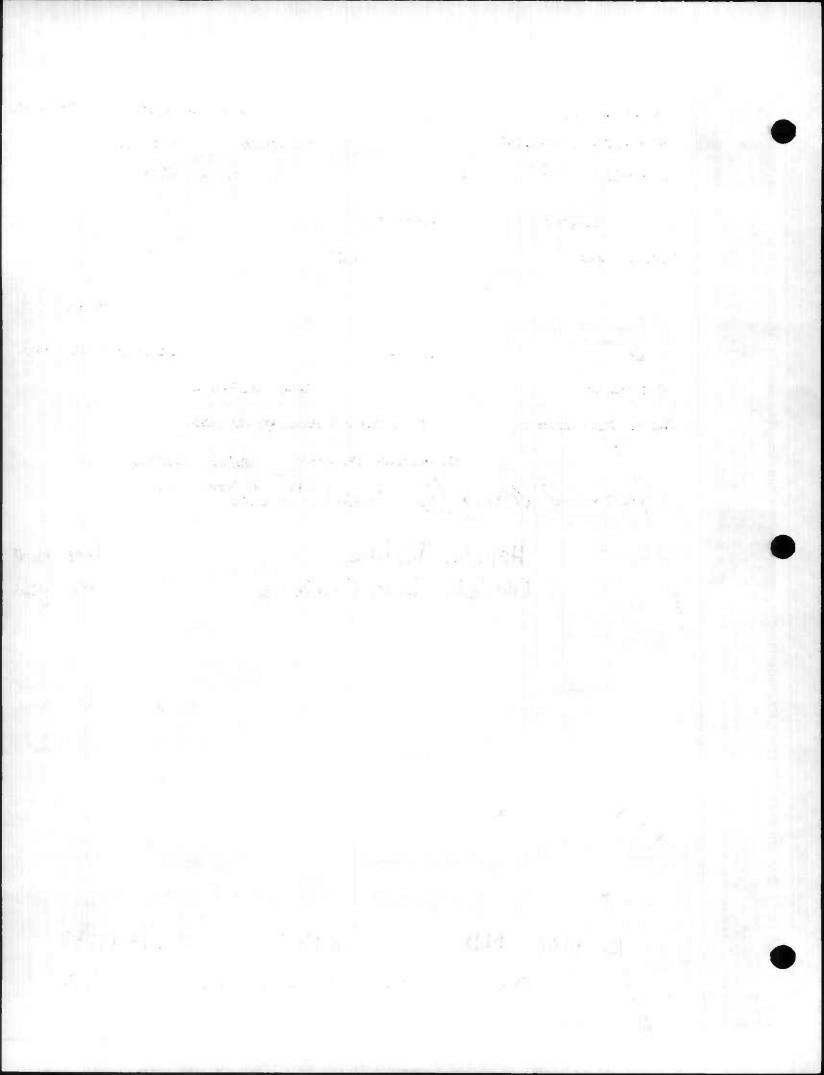
	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH															
	NORA AMEI		IFFNER							MAY	25	98	11:30 AM M			
	4. SOCIAL SECURITY NUME 219-14-6555	BER	5. SEX	6. AGE (in yrs. 80	last birthday) YRS.	IF UNDER	DAYS	HOURS	MIN.	7. DATE OF 1 (Month, Da	ly, Year)	017	Country			
	9a. FACILITY NAME (If not in	estitution, give s	reet and number)			96. CITY	y, TOWN	OR LOCATI		AUGUST			MAKY TY OF DE	LAND		
OR	ALLEGANY CO		NG HOME			(CUMB	ERLA	ND			ALI	LEGAN	ΙΥ		
ᇤ	RESIDENCE OF DEC	10b. COUNTY	,		10c CIT	Y, TOWN	OB LOCA	TION						10d. INSIDE CITY		
DIRECTOR	MARYLAND	ALLEGA				CUMB								LIMITS? XX YES 2 NO		
FUNERAL	625 COLUMBI	LA AVE	NUE				10	1. ZIP COD	502				ZEN OF W	F WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V		NO		If yes, sp		n, Maxica	NC ORIGIN? (S n, Puerto Rica		14. RACE Black, Specify				
		EDENT'S EDU		18a.	DECEDENT'S	USUAL O	CCUPATI	ON		16b. KIN	ID OF BUSIN	NESS/IND	USTRY	WHITE		
COMPLETED	Elementary/Secondary (0	y highest grade 1-12)	College (1-4 or 5	·) [(Give kind of sille. Do NOT us			ost of workii	ng	но						
No.	17. FATHER'S NAME (First, M	liddle, Last)					210	18. MOT	HER'S NA				310			
BE C	JOHN KAHL					18. MOTHER'S NAME (First, Middle, Meld MARY LULA FRIEN										
TO B	198. INFORMANT'S NAME (7		ı DAI							PA 1		State, Zip	Code)			
	20A, METHOD OF DISPOSIT	ION				O.BOX# 591 HYNDMAN, PA. 15545								vn. State		
	1 🕅 Burial 2 🗆 Crematio 4 🗆 Donation 5 🗀 Other		oval from Stata	cemetery.	TY LU	IDATEOF DISPOSITION (Name of let or you or other place) LUTHERAN CEMETERY MAY 28 1998 CUMBERLAN										
	21. SINATURE OF FUNERA	L SERVICE LIC	ENSEE .	1				ND ADDRE		FUNER	AT HO	ME				
	Nale	2.1	ent	1		1							JD MA	RYLAND		
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): 404 DECATUR STREET CUMBERLAND MARYLAND Approximate interval Between Onset and Death From Final Council															
ATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING															
CERTIFICATION	CAUSE (Disease or Injuthat initiated events reaulting in death) LAS	iry	DUE TO	(OR AS A CONS	SEQUENCE O	F):										
	PART II. Other algolfice	int condition	a contributing to	death but no	t raaulting	in the u	ndarivin	o ceuse i	niven in	Part I 24	. WAS AN AL	ITOPSV	245	WERE AUTOPSY FINDINGS		
EDICAL	RECURREN										PERFORM	ED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
	NEUROCE									_ ''	YES 2	XNO		OF DEATH?		
Σ	DID TOBACC						ATH	YES [7 NO	X				1 TYES 2 TONO		
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:			-		LACE OF D	EATH (Chi	ick only one)						
YSI	1 TYES 2 NO		1 Inpatient 2		3 🗆 DOA	4 Nur		ne 5 □ Re	sidenca	8 Other (Sp	oecify)					
ВУ РН		Pending Investigation	28e. DATE OF (Month, E		28b. TIM	E OF JURY M	WC	JURY AT ORK? YES 2	□ NO	28d. DESCRI	BE HOW INJ	URY OCC	CURED			
	3 Suicide 8	Could not be determined	26a. PLACE C building,	F INJURY — At etc. (Specify)	home, ferm,	etreet, lac	tory, offic	20		28f. LOCATIO City or To	N (Street and wn, State)	d Number	or Rural Ro	oute Number,		
COMPLETED			CIAN: To the best of													
S	2 MEDI			xamination and/	or investigation	on, In my	opinion, d	death occur	red at the	time, data and	place, and	due to the	e cause(B)	and manner as stated.		
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER																
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
	ROBUSTIAN	40 1	BLARA	era,	JR		MORI	AL HO	SPIT	TAL CUI	MBERL.	AND	MARY	LAND		
	31. DATE FILED (Month, Day,	2 6 199	8 Julya	S SIGNATURE	Bobsel											



State of Maryland / Department of Health and Mental Hygiene

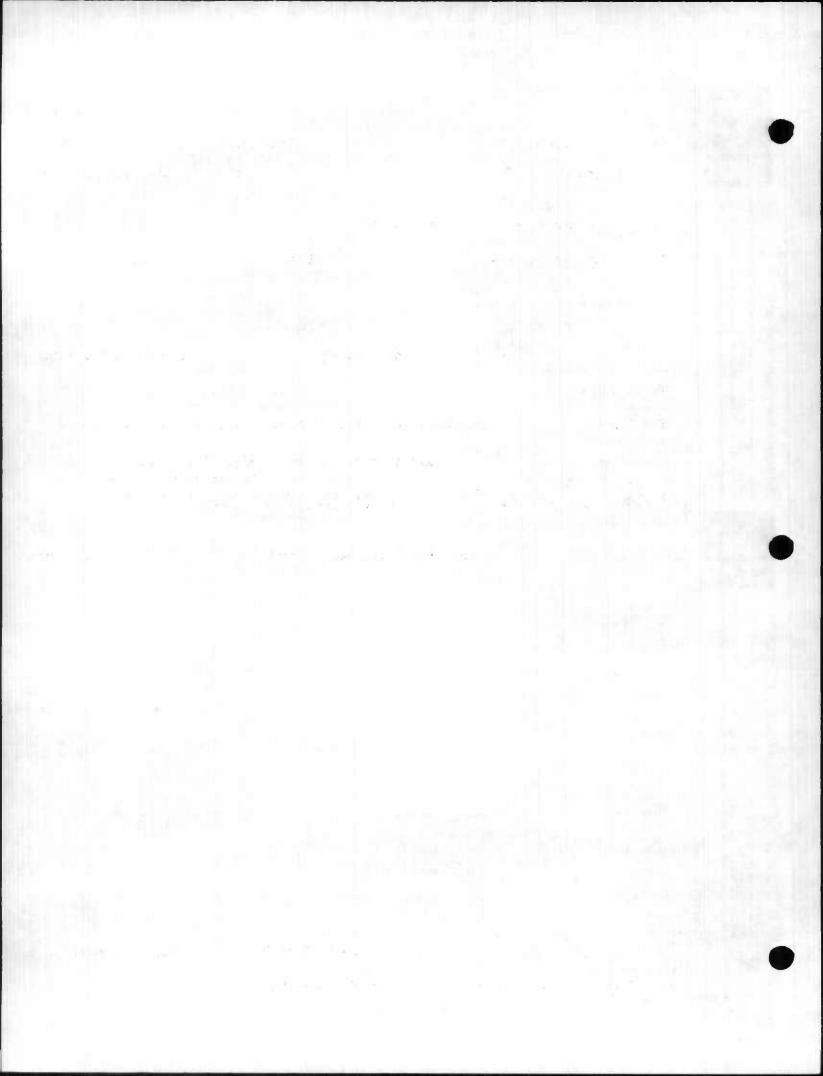
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1998 0145 A.M. MAY 18 John Luke Kiser /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not Institution, give street end number) Examiner Sacred Heart Hospital Allegany Cumberland If Under 1 Year 8. Date of Birth (Month, Dev. Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** X□M 2□F Months Deys Hours Min Yrs. Apr 27, 1934 VA Director 225-40-3732 64 Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examinar must be notified at 1 ☐ Yes X☐ No Director Rawlings MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA P.O. Box 225 21557 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Biack, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mentel Hygiene. If them 27 is marked other than "natural", or itselimportant: If them 27 is marked other than "natural", or itse 1 Yes No If Yes, Give Year or Dates: Nover Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes X☐ No Specify: Specify py 3 ☐ Widowed 4 ☐ Divorced white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethleham Steel Corp. Retired 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Loma (Phillips) John Kiser 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) P.O. Box 225 Rawlings MD 21557 Carrie Dixon-friend other t 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State injury or 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Cumberland MD 05/19 22. Neme and Address of Facility 21. Signature of Funeral Service Licensee huy Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. bo not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onsel and Death Physician /Medical . Hepatic Failure immediate Cause (Final disease or condition resulting in death) Examiner Examiner Glecholic certificate be executed physicien end the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequence of) 950 signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveilable prior to completion of cause 24a. Was an autopsy Completed peeu hes 1 ☐ Yes 2 No 1 □ Vas 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitai: No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No sida funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Attending 1 Natural 5 Pending sfter deeth. Director: Af 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 Hospital
 24 hours s
 Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. edical 29a. Certifier To the To the To the I 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifies 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Drive Cumberland MD 21502 me 921 Seton agaa 31. Date filed (Month, Dey, Year) 32 Registrer's Stynature State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Tima of Death Month **Physician** Cuc Thu Le May 21, 1998 12:55 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Gaitherspurb If Under 24 Hrs. 8. Data of Birth Hours Min. 8. Data of Birth (Month, Dey, Ye Feb. 12, 18318 Swan Stream Drive Montgomery 5. Social Security Number If Under 1 Year 6. Sex 7. Aga (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) **Funeral** Days Yeer) 1□M 2 F Months 45 Yrs. 1953 Saigon, Vietnam Director 214-13-3400 Usual Residence of Decedent with the Maryland w 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 25 No Directo Gaithersburg MD Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 end 2 should be filed within 72 hours after death with i Department of Heelth and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic avent, the Modical Examination and DRG. 18318 Swan Stream Drive 20877 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ Asian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Federal Government 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Tuong Van Le Alice S. Pham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Coda) Tua Van Le (husband) 18318 Swan Stream Drive, Gaithersburg, MD 20877 20b. Placa of Disposition (Neme of cametery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 St Burial 2 □ Cremation 3 □ Removal from Stata 5/23/98 Fairfax, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Park 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature-of Funeral Sarvice Licensae/ 500 University Blvd. West Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final Metastatic Renal Cell Cancer 12 Months disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner attending physicien end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): Box 68760. **Physician/Medical** that initiated events resulting In death) Last Due to (or as a consequence of): use as signed by the a P.0. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 2 24b. Were autopsy findings available prior to should t Completed 24a. Was an autopsy performed? completion of cause of death? certificate has t 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 8 Other (Specify) 1 Yes 2 No Certification: To this funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 5 Pending 1 SNatural 1 ☐ Yes 2 ☐ No investigation efter death. Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours of To the Funeral D completaly filled in edicai 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. (Check only one) To the P within 2 To the P 29c. Licansa number 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifiar MD 000021845 May 21, 1998 30. Name and address of person who completed caus, of death (Item 23a) (Type, Print) Jane Ingham, M.D., 3800 Reservoir Road, N.W., Washington, DC 20007 31. Date filed (Month, Dey, Year) 32 Registrar's Signature State Julia Davidson-Randell MAY 2 2 1998

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** LEUINE 1:000m EUTH /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death SILVER SOLVER 4c. County of Death Examiner 2203 WARK CT. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

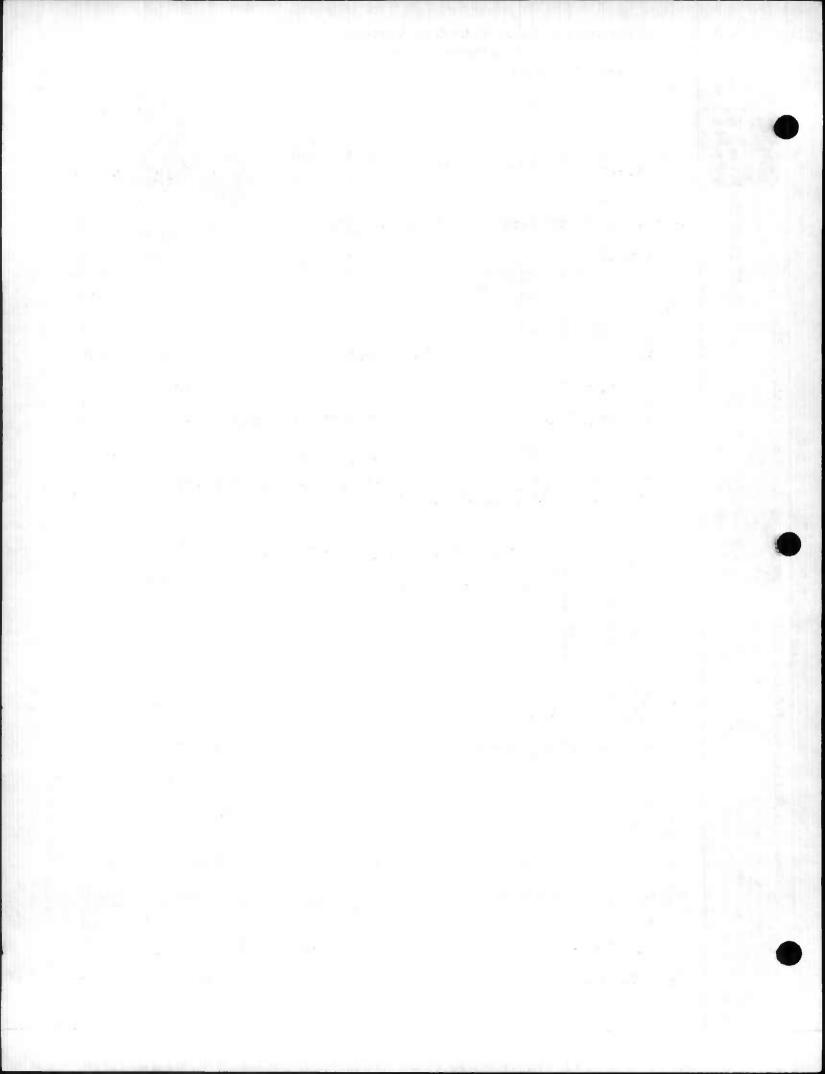
July 24, 1921 MONTGOMBIL 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 2以F 051-12-8238 76 Yrs. Director New York Usual Rasidance of Decedant the Maryland r 28a-f show a notified at 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? permit. Pages 1 and 2 should be filled within 72 hours after death with I Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 1 any injury or other traumatic event, the Medical Examines must be in 9956. 2203 Mark Ct. 20910 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican indian, Black, White, atc 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Bookkeeper Real Estate 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Hyman Wolfowitz Rebecca Weilerstein 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 4970 Pintail Ct. Frederick, MD 21713 Ross Levine/Son 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 XBuriai 2 Cramation 3 Ramoval from State 5/21/98 Olney, MD Judean Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service "Baddass Stacility Funeral Home Wilson Blvd. Arlington, VA 22201 Bun 23a. Part1. Ental tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Imm causa (Final disaasa or condition rasulting In daath) /Medical ACUTE MYOCKLOIAL INPARCTION **Examiner** Dua to (or as a consequence of): A GARLIO SCLEMENTIC CHROID VIBOUCHE DUBITY pital or Attending Physician: The law requires that the death certificate be executed ours effect deeth.

eral Director: After this certificate has been signed by the attending physician and and only by the funcated in Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributs to the cause of death? MEUITUS 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? CONGERTIVE HENCE PAILURE 1 Yas 2 NO 1 Yaa 2 No 25. Was casa rafarrad to medical examinar? Be 26. Placa of Death (Check only one) 1⊠ Yas 2□ No Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 □Othar (Specify) Certification: To 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mangar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. injury at Work? 5 Panding 1 Natural invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Sulcida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital 24 hours e cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cartifying Physician: To the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Carttin To the Within 2 and mannar stated. 29b. Signal ure and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Yaar) 15236 DMG 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print). Pike, Pockville Mb 20852 32. Registrar's Signatura

Davidson-Randelle 31. Data filed (Month, Day, Year) State MAY 2 2 1998 Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 16, 1998 В. 11:55 PM Georgene Lovecky 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death 5941 Anniston Road Montgomery Bethesda If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Months Days 1□M 2♥F Yrs. 051-22-1294 July 18, New York Uaual Residence of Decedent 10h County 10c. City. Town or Location 10d Inside City Limits 1 ☐ Yes 2 🕅 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States 5941 Anniston Road 20814 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, etc. 12. Wes Decedent Ever In U,S. Armed Forces? 1 Yes 2 No 1f Yes, Give 11. Meritel Stetus 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Council for International Elementary/Secondary (0-12) College (1-4or 5+) Exchange of Scholars Senior Program Officer 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Bertha Hajek Stephen Lovecky 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Mark J. Lovecky (son) 3680 Greenspring Road, Winchester, VA 22603 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stale 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-21-98 Beltsville, Maryland Chesapeake Crematory Rapp Funeral Services, P. A. 21. Signature of Funeral Service Licensee 933 Gist Avenue, Silver Spring, 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final Metastatic Non-small Cell Lung Cancer 1 years disease or condition resulting In death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

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24 hours Hospital

To the Hosp within 24 hos To the Fune completely fi

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Physician

/Medical

Examiner

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Completed

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Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar mast he marked.

Baltimore, Maryland 21215-0020

physician and the buriel-transit 88 use a ed by the e signed t page 2 certificate director. After this

Examiner Physician/Medical by Completed Be 2 funeral Certification: ofter death. Director: Aft

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

28a. Date of Injury (Month, Dey Year)

24e. Wes en eutopsy

24b. Were autopsy findinga available prior to completion of cause of death?

28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

1 Yes 20 No

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as atlated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury et Work?

1 Yes 2 No

29b. Signature and title of certifier

25. Wes case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 X Neturel

2 Accident

3 Suicide

29e. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Dey, Year)

5 Pending

6 Could not be determined

investigation

D 22775

May 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick G. Barr, M. D., 2101 Medical Park Drive, #210, Silver Spring, MD 20902 31. Date filed (Month, Pey, Year) MAY 1 9 1998

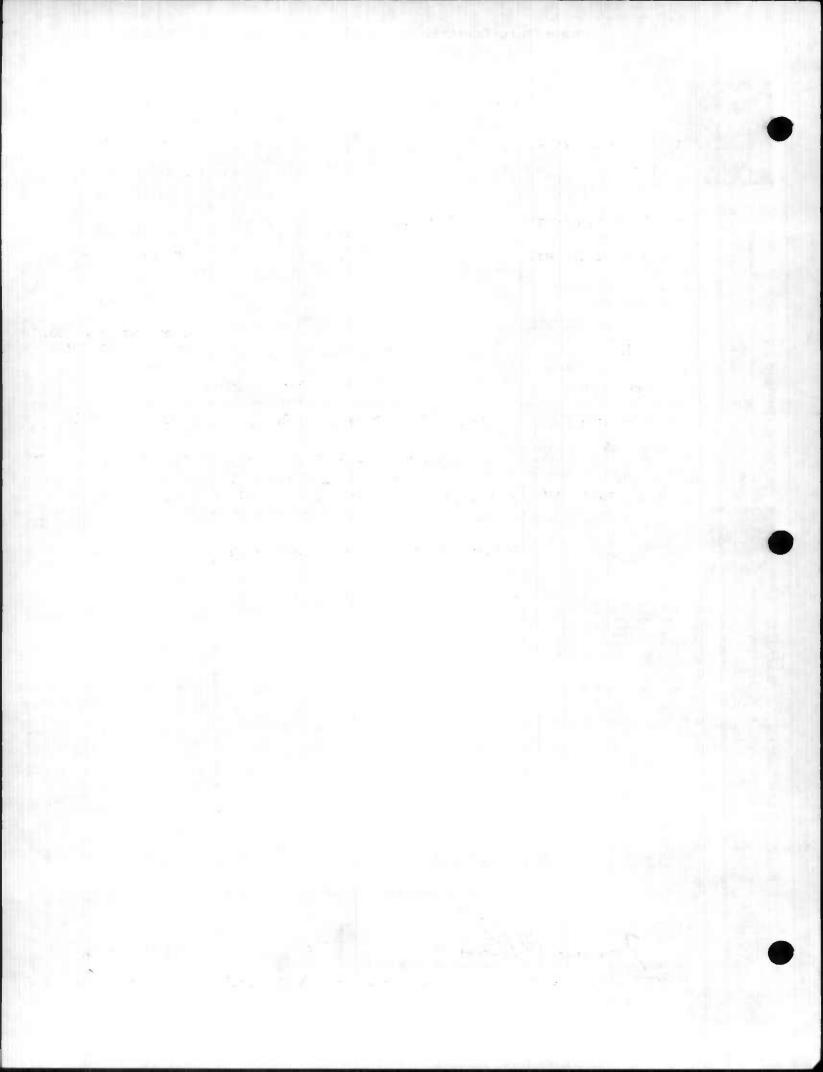
State Registrar

32 Registrar's Signature Julia Savidson-Randelle

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Data of Death 3. Tima of Death **Physician** Month Yeer BERTHA LUCHS 1998 1:40PM MAY 15, /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 1220 East-West Highway Silver Spring Montgomery #411 If Undar 24 Hrs. 5. Social Sacurify Number If Under 1 Yaar 6. Sax 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 8. Data of Birth (Month, Day, Year) Days 1□M 20 F Months Yrs **Director** 153-35-0646 June 13, 1909 New Jersey the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Silver Spring Director MD Yas 2 No Montgomery 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? with ò 20910 1220 East-West Highway #411 23a USA deeth Funeral Herrs 2 12. Was Decedant Evar In U,S. Armed Forces?

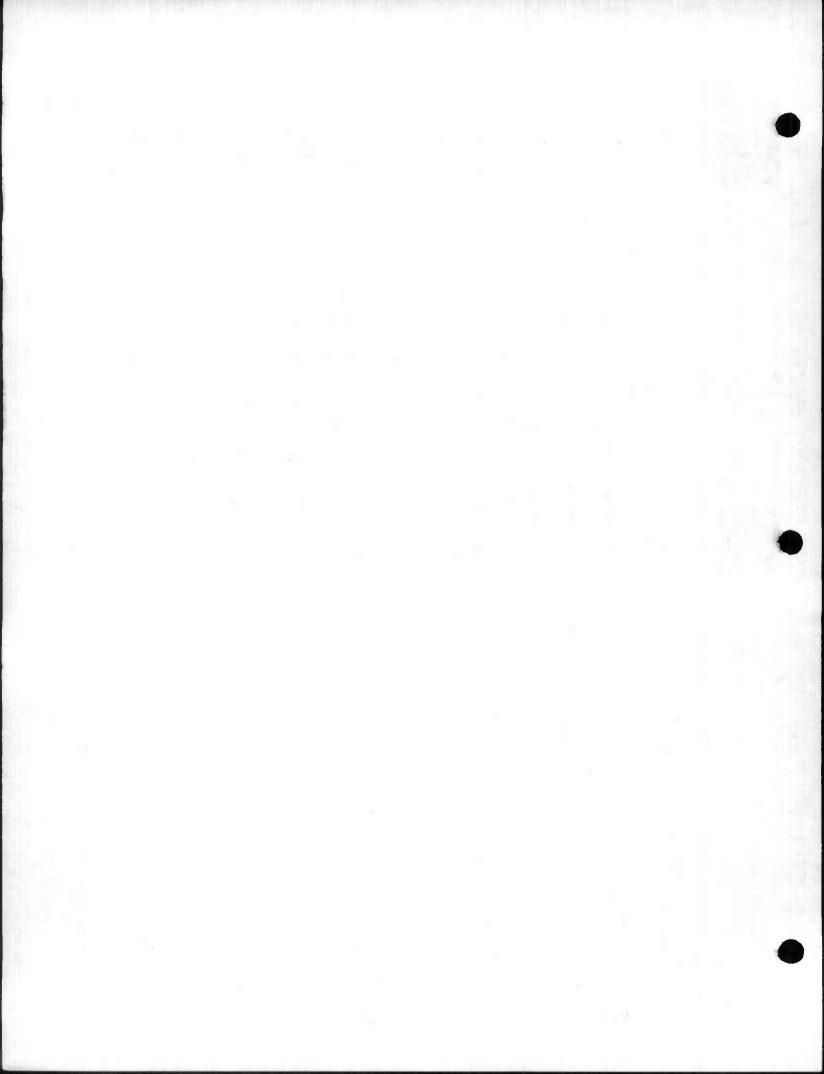
1 Yas 2 No Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 ò 1 Yas 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced "natural". Completed 15. Dacedant's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home marked other 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Malden Sumema) Pages 1 and 2 should be fill ment of Health end Mental Hant: If item 27 is marked oth ury or other traumatic even Be Hyman Barnett Bessie Krammer 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Rockville, MD 20853 Lorin Luchs (Son) 14712 Myer Terr. 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition
1 Buriel 2 □ Cramation 3 □ Ramoval from State 20c. Location - City or Town, Stata permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) 5-17-1998 Washington, DC Ohev Sholom cemetery 21. Signature of Euneral Service Licensee 22. Nama and Address of Fecility
Danzansky-Goldberg Memorial Chapel, Inc 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrasf, shock, or heart failure. List only one cause on each line. Approximata Interval Betwaan Onset end Death **Physician** /Medical Immediata Ceusa (Final disaase or condition resulting in death) CONGESTIVE HEART FAILURE 3-6 MONTHS Examiner Dua to (or es e consaguance of). Examiner CARDIOMYOPATHY The law requires that the death certificate be executed ettending physician and for use es the buriel-transit Sequantially list conditions, if any, laading to immediata ceusa. Enter Underlying Causa (Diseasa or injury that initiated avants resulting in death) Lasf Dua to (or as a consequence of): Box 68760. AORTIC STENOSIS YEARS Physician/Medical Dua to (or es a consequance of) P.O. been signed by the should be deteched Pert II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to complation of ceusa of death? Completed 24a. Was an autopsy performed? page 2 hes 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificete Division of Vital or Attending Physician: director, Be 25. Wes cesa referred to medical 26. Plece of Deeth (Check only one) examinar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Homa 5 🕅 Rasidance 6 Othar (Specify) 2 1 Yas 2 X No /s efter de... ral Director: After ... hv the funeral di 27. Menner of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification; 1 Neturel 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarminad Place of Injury - Af homa, farm, straef, factory, office building, atc. (Spacify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) filled in by 4 Homicide To the Hospital
within 24 hours e
To the Funeral E Hospital 29a Cartifiar Medical 🔯 Cartifylng Phyelclan: To tha best of my knowladga, daath occurrad at tha tima, dete end place, and due to tha ceusa(s) and mannar as steted. completely 2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred of the time, date and place, and due to the cause(s) and mannar stated. 29b. Signatura and fifle of certified 29c. Licansa number 29d. Date signed (Month, Day, Yaar) May 16, 1998 30. Name end eddrass of person who completed cause of death (Item 23e) (Type, Print)
Karen L Jerome, MD 8700 Georgia Avenue, Ste 400, Silver-Spring, MD 20910 31. Data filed (Month, Day, Yeer)

State Registrar

MAY 1 9 1998

32 Registrar's Signetura - Randell

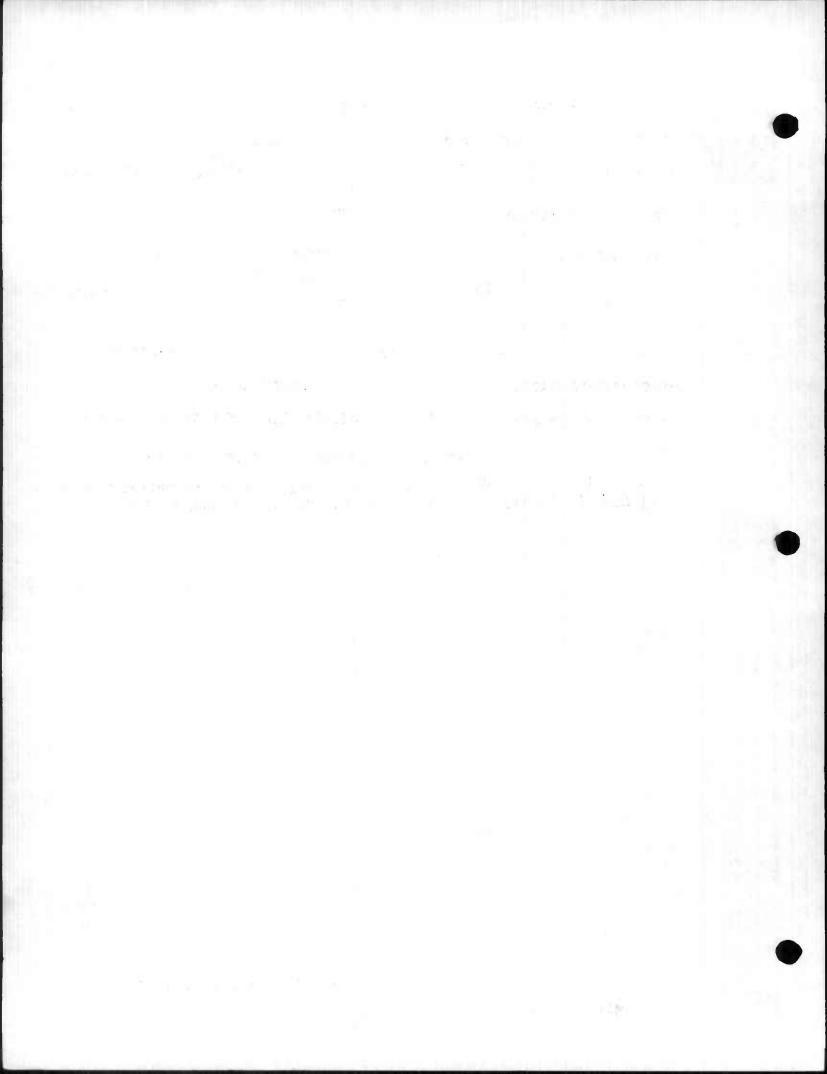
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		Dhuala	lan.	1. Decedent's Nam	ө (First, Middl	le, Last)									2. Date of De Month	eeth	th Day Year		3. Time of Death	
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		the Marylend 28a-f show	5		10b. County				Oc. City, Tov		cation							1	0d. fnside City Limit: 1 ☐ Yes 2 No.	
		the N	Director	Maryland 10e. Street end Nu	Talbo	t]	Bellev	rue	10f. Zip	Code				100.0	'Hizon of V	Mhat Cour		
		ours after death with the Maryler al', or Items 23a or 28a-f show Examinet must be notified at		5658 Ga		root						2166	2					Vital Cour	t Country?	
		death me 23	Funeral	11. Marital Stetus	LCS DE	12.	Was Deca Armed For	dent Eve	er in U,S.	13. V	_			igin? (Sp	ecify Yes or No Rican, etc.)	USA o-	14. Rac	e - Americ	an Indian,	
	2	or the	/ Fu	1 Never Marr		ried	1 ☐ Yes If Yes, Giv	2 XNo			res, spec I□Yes 2				Hican, etc.)					
	00	hours a	d by	3 XWidowed			Year or Da	ates:	140							1	Specify	вта	Black ess/Industry	
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/ce	21	od with	Com	Elementery/Second	ondary (0-12)		College (1 2 yrs		Co	mput	ter P	rogr	amer					of Maryland roller Division		
Jo	pur	permit. Pages 1 and 2 should be filled within 72 hours beginned. I health and Manfall Hyganes. Introcreate; if item 27 is marked other than "natural; any injury or other traumatic event, its Medical Engles.	Be	17. Father's Neme						•				er's Nem	e (First, Middle	e, Maide	n Sumem	10)		
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ma		lith en 27 is r			Gibson		,	.)							ral Route Numb narylan			Stete, Zip	Code)	
pu	ore,	other		20a. Method of Disj	position				20b. Place of	of Dispos		ne of		-01191	Date		Location -	City or To	wn, Stete	
La	Ē	Pege net c int: if		1 Burial 2 4 Donation			oval from S	State	Maryl					n. 5	5/22/98	Bet	ılah,	Mary:	land	
	Baltimore,	permit. Peges 1 end 2 s Depertment of Health er Important: if Item 27 is any injury or other trau 200.68.		21. Signeture of Fu	neral Service	Licanse	-		_	22	. Name and									
	ш	ZO = 3 3		1						>					21601,		2.O.B	ox 1	687	
				23a: Pert1. Enter to shock, or hea	he disease, of rt fallers. List	complication one ca	ause on ea	sused the	e death. Do	not ente	er the mode	of dyln	g, such as	cardiac	or respiretory	errest,			Approximate interval Between Onset end Deeth	
	9	Physician /Medical		Immediate Ceuse (Final			R		0	60.10	n		- 0	w 201)	0	5- 15 W	1
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	Box	The law requires that the death certific the has been signed by the attending page 2 should be deteched for use as:	any			d														
	_	the a	ysic	Pert II. Other signif	leant conditte	ns contribu	uting to dea	ath but n	not resulting	In the un	derlying ca	use give	en in Part	l.	23b. Dfd tobacco use contribute to the cause of deat					
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oyc		The law ate has page 2	Completed	Rece	l la	ele.	10	Ne	vers	00	wit	VIII.	onle	ut	10	Yes :	2 2 No	10	Yes 2□ No	
50	Vital	ysician: The last certificate had director, page	Be	25. Wes case reference examiner?	red to medical						7			e of Deat	h (Check only	one)		l		
1,	of		-T	1 Yes 2		Hosp	1 🗆 10		2 ER/O			1	4 🗆 140	ursing Ho	me 5 Res				1)	
nar		ding I h. After funer	tion	1 Natural 2 Accident	5 Pendin		8a. Date o (Month	n, Day Ye	ear) 280.	Time of tnjury	M	Bc. Injury Work	ret ⊲? Yes 2□	No	28d. Describe	now inji	ury occurr	ed		
Landman	Division	Attending or deeth. ector: Afte by the fune	Certification:	3 Suicide	6 Could r	not be	8e. Plece	of Injury	- At home, fa	arm, stre					28f. Location	(Street e	nd Numb	er or Rura	l Route Number,	-
Lai	Ö	rs effer al Direction by	Cert	4 Homicide			buildin	g, etc. (S	Specify)						City or To	wn, Sta	fe)			
		To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral	edical	29st. Certifier (Check only	12 Certifyin 2 Medical I	Examiner:	On the bas	SIS OF OX	aminetion ar	e, deeth	occurred e	t the tim	e, dete en sinlon, dea	d placa, th occur	and due to the	cause(s) and me	nner es st	eted. the cause(s)	
		ithin 2 o the	Med	one) 39b Signature and	title of certifier		and mann	er stated	1.		29c	License	number			29d. D	ate signed	(Month.	Dey, Year)	-
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			1	ame and eddre	ess of person	who comple	eted cause	of deet	h (Item 23a)	(Type, F	Print)	50	- 00	- (,			
				Lawrence Bohan, M.D., 606 Dutchman's Lane, Easton, Maryland 21601																
		Sta		31. Date filed (Mont	n, Day, Year)		32. Re	gistrer's	Signature				,					_		
		Registr	ar		IAY 22	1998		anna	Davidso	n-193	ndesse							<u>.</u>		



State of Maryland / Department of Health and Mental Hygiene O

					Cei	tificate of	Death		Reg. No.	0	1089			
	Physic	an	1. Decedent's Name (First, Middle, Last,					2. Dete of Dee Month	Dev	Yeer	3. Time of Deeth			
J	/Medi		Paul Richa			Lawrer		May 19	, 1998		12:15 AM			
	Examir	ner	4a. Facility Neme (If not institution, give		dow/owo		4b. City, Town, or							
_			Salisbury Center: 5. Social Security Number 6. Sec		In yrs. last birthdey)	If Under 1 Year	Salisbur		Wicom					
П	Funeral Director			M 2□F 87		Months Deys		MAY 26,	7, Yeer) 1910	PENN	plece (Stete or Foreign ntry) SYLVANIA			
	p.		Usuel Residence of Decedent											
	show	ž	10a. Stete 10b. County WICC	OMICO	Oc. City, Town or Lo	cetion SALISBURY	Y			10d. Inside City Limits 1 Yes 2 □ No				
	the M	Director	10e. Street end Number	711100		10f. Zip Code	•		10- Chi11	10-10-				
	with with		200 CIVIC AVENUI	7			21804		10g. Citizen of N USA		ntry?			
	Jeath Tris 23	Funeral		12. Wes Decedent Eve	er in U,S. 13. \		Hispenic Origin? (S ban, Mexicen, Puerl	pecify Yes or No-			cen Indian,			
)20	be filed within 72 hours efter death with the Manyland tial Hygiene. Id other than "netural", or items 23s or 28s-f show event, the Medical Exercitive must be notified at	by Fur	1 Never Merried 2 Married 3 🖫 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Detes:		f Yes, spacify Cut 1 ☐ Yes 2 🎛 No		o Rican, etc.)	ck, White,	etc. WHITE				
21215-0020	2 hou	Pe	15. Decedent's Edu	cation	16e. Deced	lent's Usuel Occu	petion		16b. Kind of B	16b. Kind of Business/Industry				
215	thin 7.	Completed	(Specify only highest grade Elementery/Secondary (0-12)	e com <i>pleted)</i> College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of world)	rking			,			
	filed will Hygian ther the	Con	11	-0-	FARI	1ER			AGRICUL	TURE				
aryland	tal H d oth	Be	17. Fether's Neme (First, Middle, Last)					ne (First, Middle,	Maiden Surnan	ne)				
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	alth end 27 is m		19e. Informent's Name/Reletionship (Ty ROBERT M. LAWRENCI				et and Number or Ru BURY BLVD							
re,	s 1 end 2 should f Health end Mer item 27 is marke other traumatic		ROBERT M. LAWRENCE/SON 1610 N. SALISBURY BLVD., SALISBURY, MD 2 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or other place)											
Itimore,	Pages nent of int: If its iry or o		1 M Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ST. PAUL :			5-22-98	CORDOVA	, MD				
alti	그들은		21. Signeture of Funeral Service License		22	. Name and Addr	ess of Feclify			•				
m	Depariment of the part of the		M-F/ORY	nam - C							OME, P.A.			
	-		23e. Pert1. Enter the disease, or complishock, or heart feilure. List only or	cations that caused the	e deeth. Do not ent	or the mode of dy	RISON ST.	or respiretory er	rest,	1001	Approximete Intervel Between			
	Physician		orious, or rount rollate. Electrony of	o occor on ocon into.						- 1	Onset and Death			
	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)	Come	Je8 Due	_ les	ANT F	Alux						
		-	resulting in deality	. 00	e to (or es e conseq	uence of):	0		7 0	1	1 0100			
Т	ited insit	min	Immediate Ceuse (Finel disease or condition resulting in death) e. Ceryses The Dental Plent Faulure Due to (or es e consequence of): Will Skearn and Plent Faulure Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Ceuse. Enter Underlying Ceuse. Due to (or es e consequence of): Ceuse. Enter Underlying Ceuse (Disease or injury Ceuse (Disease or injury)											
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68760,	ysicia	Icai	that initiated events											
	E 00	Med	resulting in deeth) Last Due to (or es e consequence of):											
Вох	ath ce ttendi	lan/												
0	The law requires thet the death cer ata has been signed by the eftendir page 2 should be datached for use	Physician/Medical	Pert II. Other significant conditions con	tributing to death but r	not resulting In the u	nderlying cause gi	iven In Pert I.	23b. Dld t	obacco usa co	ntribute t	o the cause of death?			
0	res thet tigned by		1 tment	V3-				101	res 2□ No	3 Pro	bably 4 Unknown			
Records,	n sign	ed by	1 Soll	C.1.				24a. Wes	en eutopsy	24b. W	ere autopsy findings			
000	s been si 2 should	Completed	Butda	Corri	cer			репо	med?	CC	velleble prior to empletion of ceuse deeth?			
	The law ita has bage 2	mo						1 🗆 Y	es 2 No	11	□Yes 2□No			
Vital		Be C	25. Wes case referred to medical examiner?				26. Place of Dec	eth (Check only o	ne)	1				
<u>></u>	Physician: r this certific and director,	To	1 ☐ Yes 2 ☐ No		2 ER/Outpetien	f 3Ll DOA		lome 5 ☐ Resid	ence 8 🗆 Oth	er (Speci	fy)			
L C	Ing P	ion:	27. Manner of Deeth 1 □ Natural 5 □ Pending	28e. Dete of Injury (Month, Dey Y	(ear) 28b. Time of Injury	28c. Inju		28d. Describe h	ow injury occur	red				
Sic	Attending or death.	icat	Accident investigation 3 Suicide 6 Could not be	20a Plan of Injun	At home form atr		Yes 2 No	28f Location /5	Street and Numb	her or Pur	el Boute Number			
Division of	after Direct Jin by	Certification:	4 ☐ Homicide determined	building, etc. (- At home, farm, str Specify)	set, rectory, office	tory, office 281. Location (Street and Number or Rural Route Num City or Town, State)							
_	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completaly filled in by the funer	edical C												
	the the the F	Medi												
	N V V		29b. Signeture end fittle of certifier	_		29C. Liden	701 G	17	29d. Date signe					
			30. Name and address of person who co	moleted cause of deet	h (Item 23e) /Tune	Print)	3901		0/0	16	10			
			and and an below!! will on	Pieres oreses or deal	(200) (1)be'	/								

State Registrar 1104 Healthway Dr., Salisbury, MD 21804



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 17, May 1998 CANDACE LANE 11:00 A.M. VIOLA /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 312 Thomas Lane Frederick Frederick If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number If Undar 1 Yaar 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 2 F Months Days Hours Yrs. **Director** 416-07-4876-D 98 April 14,1900 Massachusetts Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylend Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumstic event, the Medical Exercipet with the notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Thomas Ave. 21701 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify. White by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 12 Homemaker own home 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Charles Rankin Daisy Palmer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Paul R.B. Lane / son 279 Wyngate Dr./ Frederick, Maryland 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cramatory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hagerstown Crematory 5-18-98 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee In Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock or heart tailura. List only one cause on each line. 1621 Opossumtown Pike/ Frederick, Maryland 21702 Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner scular Beadent Examiner retrova physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last Due to (or as a consequence ot) Physician/Medicai Due to (or as a consequenca of) 80 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to Completed complation of causa of deeth? certificate has b lirector, page 2 sl 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examinar? Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this funerel 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation Natural 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 Sulcida 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 | Homicide

🈢 Certifying Physician: To the best ot my knowledge, death occurred et the time, date and piece, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and dua to the cause(s) and manner stated.

29c. License number

516

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0020

requires that the death certificate be executed

or Attending Physician:

death.

24 hours e Hospital

within 2 To the

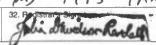
completely

Division of Vital Records, P.O. Box 68760,

8 199

29b. Signature and titla of certifian

Name and address of person



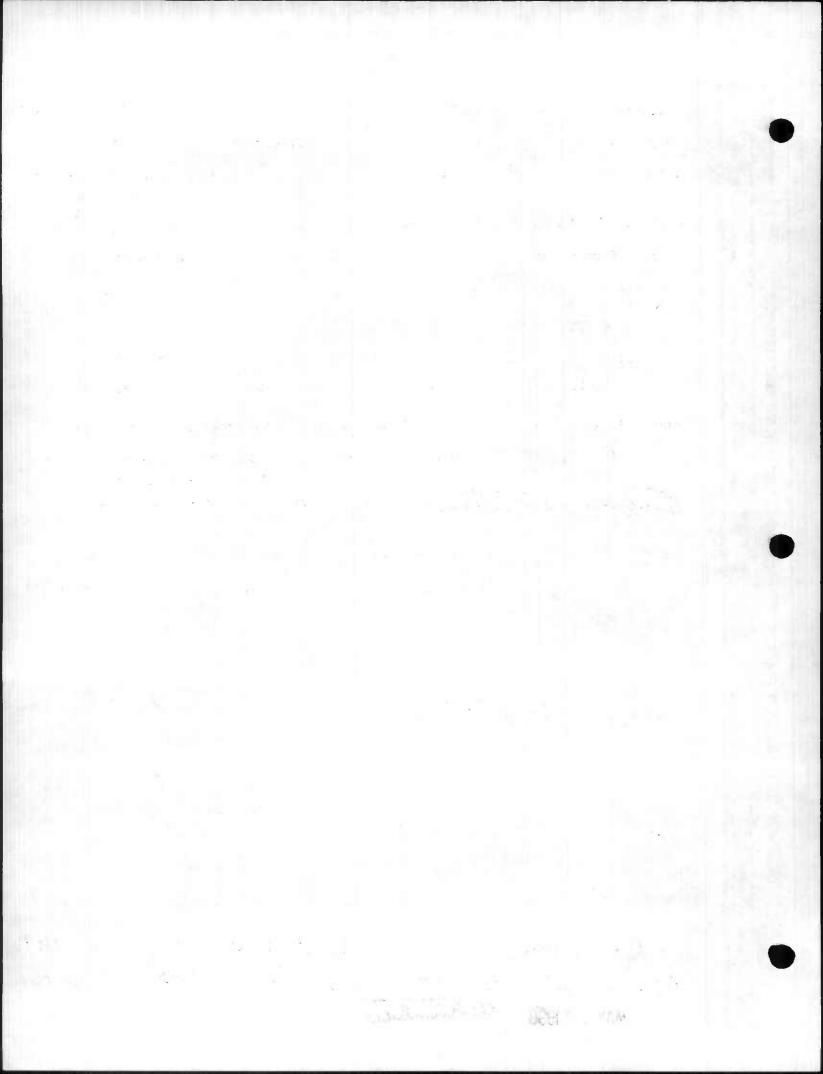
mpleted cause of death (Item 23e) (Type, Print)

State Registrar

Medical

29a. Certifier

(Check only one)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day Yee HELEN ELIZABETH LOWE MAY 20 1998 19:45 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY if Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days 1 □ M 2 1 F Months Hours Yrs. 351-09-6191 81 JAN 19,1917 NEBRASKA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. LIBERTY STREET 21502 USA 11. Maritai Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Crigin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Never Married 2 Married Yes 2 No f Yes, Give 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 AGENT REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) FRANK ULMER NINA BETTY 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zlp Code) JODY GOTTSCHAMER/DAUGHTER 509 HIDDEN WAY #103, VIRGINIA BEACH, VA23454 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other piece) 1 X Burial 2 ☐ Cremation 3 ☐ Removat from State HILLCREST MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND, MD 21 Constum of Furning Service Licensee 22. Name and Address of Fecility HAFER CHAPEL OF THE HILLS MORTUARY NATIONAL HWY, LA VALE, MD 1302 21502 23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cerdlac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) a Intractable Congestive Heart Failure 6 mos. Due to (or as e consequence of): Due to (or as a consequence of): Due to (or as a consequence of). Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings eveilable prior to 24e. Was en eutopsy performed? completion of ceuse of death? 1 Yes 1 Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medicai **Examiner**

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physician

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certificate

this funeral

After

within 24 hours energy To the Funeral Director: Aft

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page 2 should

director,

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Completed

Be

Certification: To

Medical

The law requires that the death certificata be axecuted

Records, P.O. Box 68760,

Division of Vital

HELEN LOWE

To the Hospital or Attanding Physician:

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at

Director

Funeral

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other

permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event

other traumatic event,

altimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Physician/Medicai

> 25. Was cese referred to medical examiner? spital: 1 Inpatient 2 | 28a. Date of Injury (Month, Day Yeer) Hospital: 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2X No 1 Yes 27. Menper of Deet 1 Natural 2 Accident 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide

28b. Time of 28c. Injury et Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

20b. Signature 15

29c. License number D 16041

29d. Date signed (Month, Dey, Year)

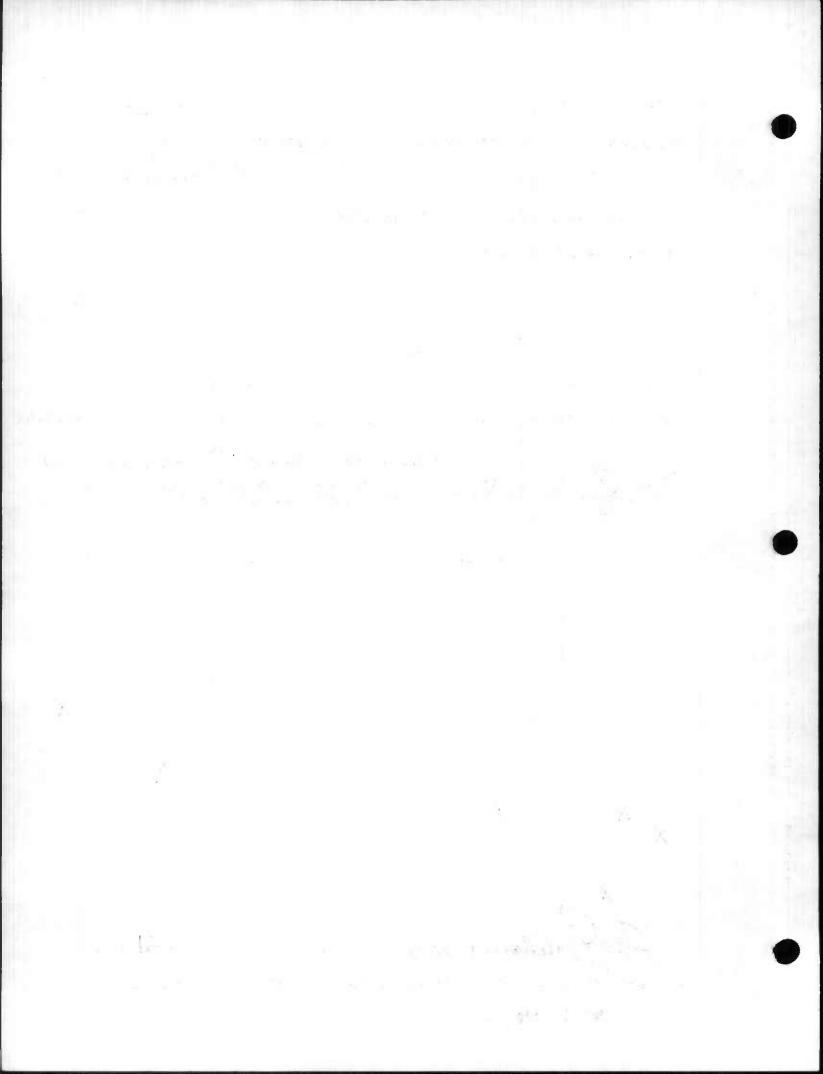
30. Name and addre rson who completed cause of death (Item 23a) (Type, Print)

1998 MAY A

DR. TERRY WILLIAMS, MEMORIAL HOSPITAL MEDICAL BUILDING, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature Jaka Studson his dall MAY 22

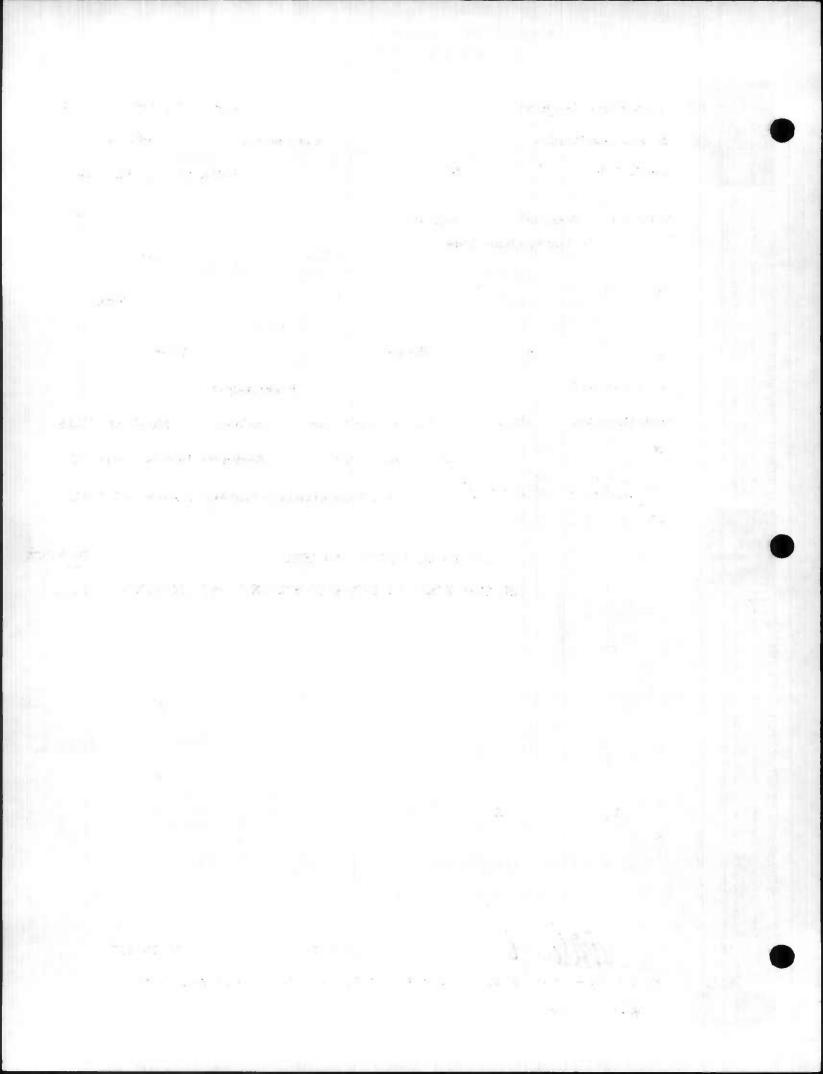


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Joshua Paul Livingston MAY 16 1998 4:15 PM /Medical 4e Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Sacred Heart Hospital Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 5. Sociei Security Number 7. Age (In vrs. lest birthdev) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Devs Hours Months 1 M 2□ F 216-25-2668 Yrs 14 Director 17-Dec-83 Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinal mast be notified at 1 Yes 2 □ No Director Maryland Allegany Frostburg 10e. Street end Number 10f. Zio Code 10g. Citizen of What Country? 180 East Mechanic Street 21532-U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritai Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White λq 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pemit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than any Injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Student Student 8 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Joe P. Livingston 0 Paula Skipper 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paula Livingston Mother Maryland 21532-180 East Mechanic Street Frostburg Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20-May-98 Frostburg, Maryland Frostburg Memorial Park 22 Name and Address of Fecility 21. Signeture of Funeral Service Line GRM Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Pm1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, not heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel 24 hours diseese or condition resulting in death) CARDIO-RESPIRATORY FAILURE Examiner Due to (or es a consequence of) SINCE Examiner SEIZURE DISORDER SECOND TO STURGE WEBBER SYNDROME BIRTH and burial-tran Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting In deeth) Last Due to (or es a consequence of) the death cartificate be exec Box 68760 physician Physician/Medical the Due to (or es a consequence of) 80 esn ŏ signed by the a 23b. Did tobacco use contributs to the cause of death? Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. O 1 Yee 2 No 3 Probably 4 Unknown نم Records, à 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen aw hes page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific. director, Be 25. Was cese referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of Injury et Work? 5 Pending Investigation Injury 1 X Naturel after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide pellil 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and manner as stated. Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and mayiner stated. 29d. Date signed (Month, Dav. Year) 29b. Signeture and title of certified 29c. License number D19032 MAY 19 1998 ho completed cause of death (Item 23e) (Type, Print) 30. Name end eddres ns 21502 ELMASLIÁS MENCHAVEZ M.D. 902 SETON DRIVE CUMBERLAND MARYLAND 31. Date tiled (Month, Day, Year)

KAY 2 0 1998 2. Registral's Signature State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Dafa of Death 3. Time of Death Month Yaar **Physician** Nuri Malley May 17, 1998 3:00 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Nema (If not Institution, giva street and number) 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Deys Months 1⊠M 2□ F Hours 547-24-0995 89 Jan. 10, 1909 Syria Director Usual Residence of Decedent with the Meryland r 28a-f show 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo California San Diego La Jolla 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code than "natural", or items 23s or the Medical Examiner must be a 2504 Ellentown Road 92037 United States permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Example 10026. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates; 14. Race - American Indien, 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Marriad 2 ☒ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentery/Secondery (0-12) College (1-4or 5+) Biology Entomologist 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Unknown Malih Unknown 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. fnforment's Neme/Reletionship (Type, Print) James D. Malley/Son 1840 Greenplace Terrace, Rockville, MD 20850 20b. Plece of Disposition (Neme of cematary, cremetory or other pleca) May 19, 1998 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burlal 2 A Cramation 3 ☐ Removel from Stete Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

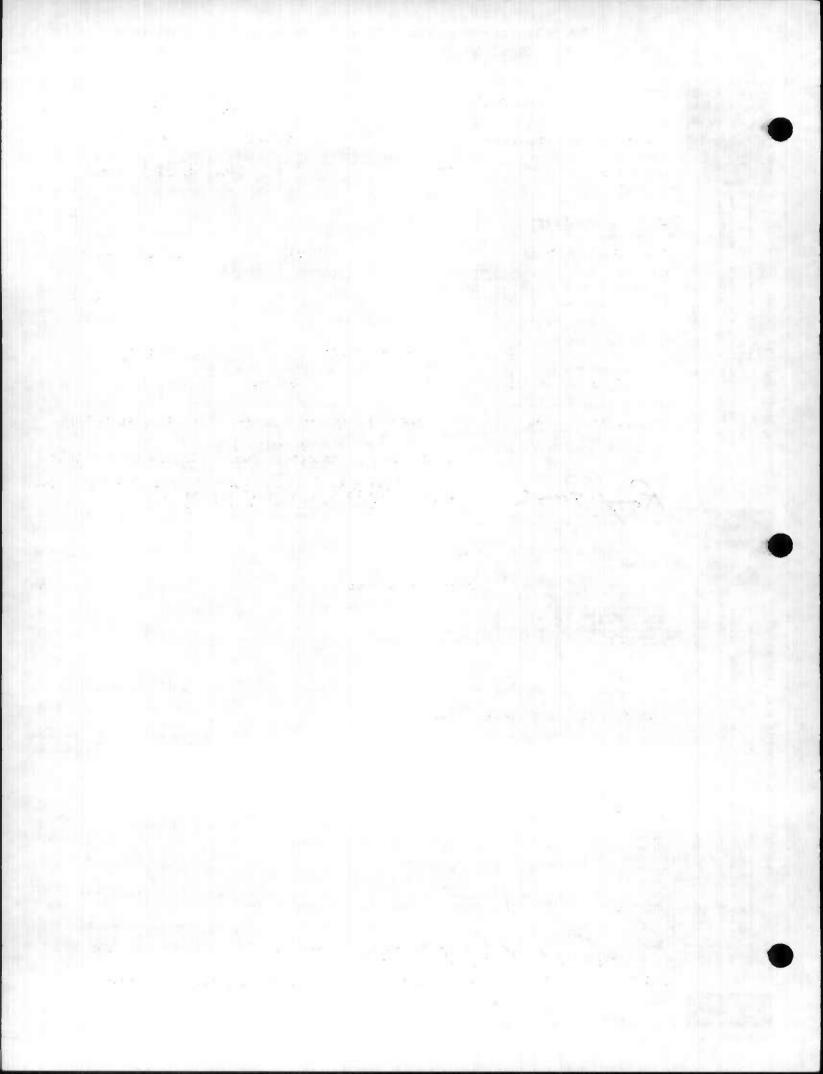
23a. Peril. Enterthe disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate Approximete Intervel Between Onset and Deeth **Physician** Immediete Ceuse (Final disaesa or condition resulting in death) /Medical Stroke 24 hours Examiner Due to (or es e consequenca of): Examiner Cerebral Arteriosclerosis 15 years death certificeta be executed physician and the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or es e consequence of) as I 980 ò ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o. the 1 Yes 2 No 3 Probably 4 Unknown that signed t Senile Dementia (multi infarct) Division of Vital Records, by should b 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? The lew hes certificate he 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending investigation 1 Yes 2 No death. 2 Accident after death Director: n 24 hours after dea he Funeral Director relately filled in by th € ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es stated.

Third call Experimen: On he basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certif 29c. Licansa number 29d. Data signad (Month, Day, Year) D07471 May 18, 1998 ted cause of deeth (Item 23e) (Type, Print) 30. Name and address of person who 50 West Edmonston Drive, Rockville, Maryland Paul T. Noone, M.D. 31. Dete filed (Month, Dey, Yeer)

State Registrar

MAY 2 1 1998





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month 8001, 18 **Physician** 10:45 AN SELMA 100 MILLER /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Fort Washington Hince Fort Washir KITEY HOSPHA CHEORGES Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) **Funeral** 1 M 2 F 73 Yrs Director 237--36-6496 Nov. 3, 1924 NC Usuai Residence of Decedent 10a. State 10c. City, Town or Location 10d. Insida City Limits YOYes 2 □ No Director DC NA Washington 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code in "natural", or items 23a or 3 Medical Examiner must be n 1359 Jefferson Street, N. W. 20011 Funerai United States 12. Was Dacedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 Navar Marriad 2 Married 1 Yas 2 XNo If Yes, Give Yaar or Datas: 1 ☐ Yas 2 XNo Specify: Specify: Black þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 12th Nurse Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve Alfred Green Nattie Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerlene Rountree /neice 1359 Jefferson St., N.W., Wash., DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 Buriai 2 ☐ Cremation 3 ☐ Removai from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 5/22/98 Brentwood, MD 21. Signature of Funaral Service Licenses 22. Name and Address of Facility R. N. Horton Co. Morticians, Inc. n. Wallow 600 Kennedy St., N.W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediata Cause (Final diseasa or condition rasuiting in death) Myocardial Infarction /Medical 1 mmediate Examiner Due to (or as a consequence of); /manary Embelism Physiclan/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasl 88 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension ģ 24b. Were autopsy findings available prior to complation of causa of death? ial Fibrillation 24a. Was an autopsy performed? page 2 s Enlarged Heart 1 Yes 2 No 1 Yas 2 No 25. Was casa referred to medical axaminer? 26. Piace of Death (Check only one) 1□ Yes 2No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury al Work? Certification: MA Injury 1 Natural 5 Pending MA 1 Yes 2 No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: s after death. 24 hours a Hospital To the Hosp within 24 ho To the Fune completely fi

29b. Signature and title of course

29c. License number

29d. Date signed (Month, Day, Year)

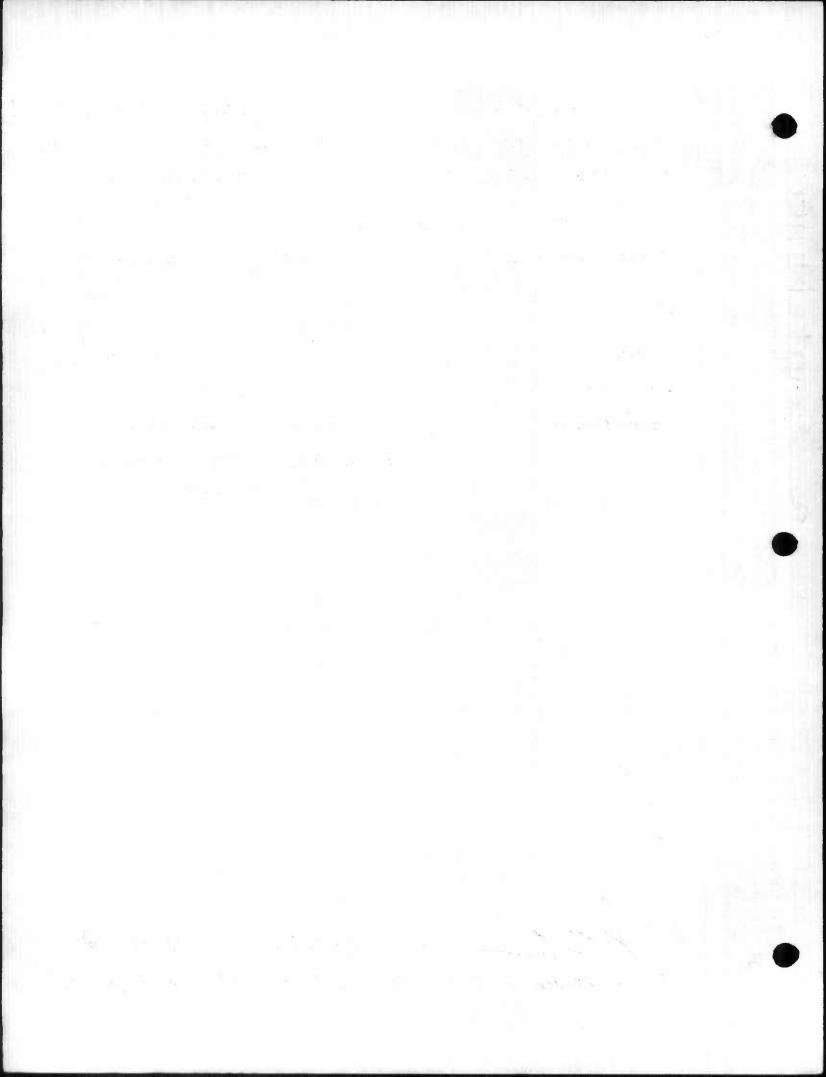
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Felton Huderson MO 2025 I ST N.W. #915 Washington D.C.

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature MAY 2 1 1998 gittle Davidson-Randelle



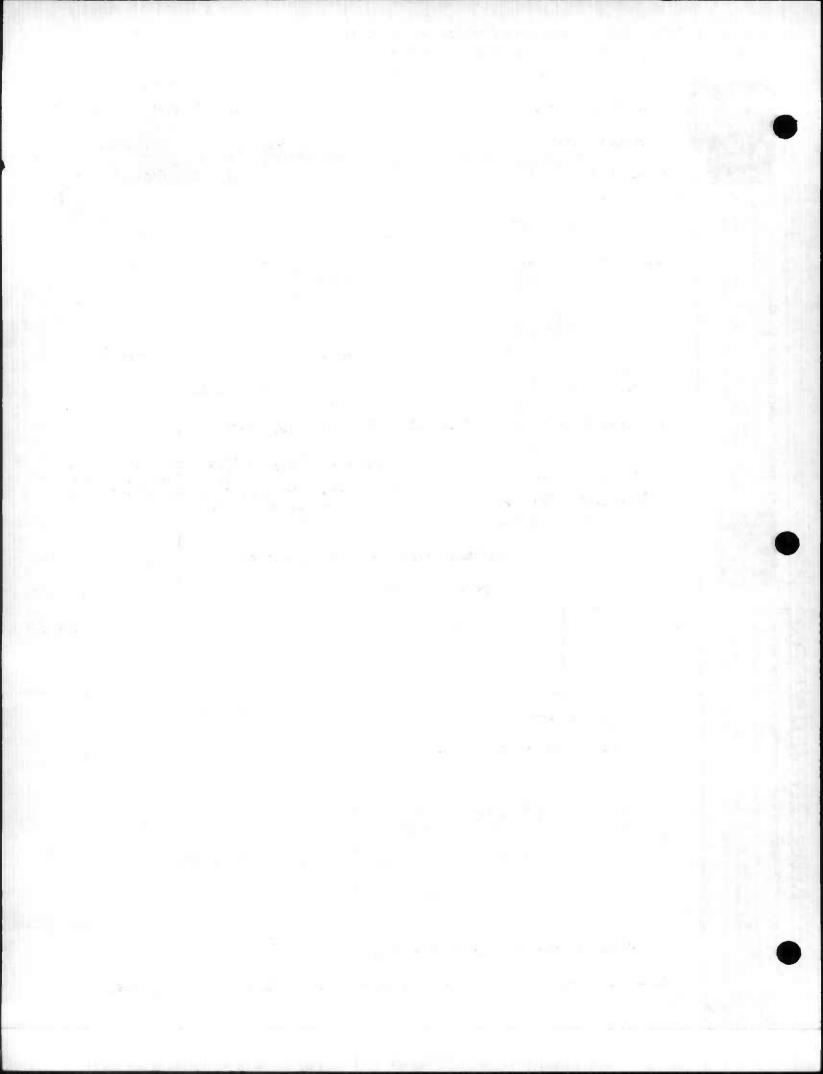
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Year Robert F. Mascari May 15, 11:30 AM 1998 /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (fn yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F Yrs. Director 052-26-8073 65 Sept. 15, 1932 New York Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MD Montgomery Rockville 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 15312 Narcissus Way 20853 USA Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 72 hours after 1 x Yes 2 No If Yes, Give Yeer or Detes: 1956-58 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Retail Manager permit. Peges 1 and 2 should be filed Department of Health and Mental Hygis Important: if Itan 27 is marked other any injury or other traumatic avant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be Frank Mascari Maria Calabrese 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia W. Mascari (wife) 15312 Narcissus Way, Rockville, MD 20853 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery | 5/19/98Silver Spring, MD 21. Signature of Funeral Service Lic 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23e. Per I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical Diabetes Mellitus - Complications 6 months Examiner Due to (or es e consequence of): Type I Diabetes 25 years Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): physicien Yeast Peritonitis 4 weeks Physician/Medical the Due to (or es e consequence of): USB ò Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yee 2 □ No 3 □ Probably 4 □ Unknown Hypertension þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed End Stage Renal Disease pege 2 s 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours effer deeth.
 Funeral Director: Affer this certifica director 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1 ∏Inpatient 2 □ ER/Outpetlent 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled In 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) May 17, 1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Eugene P. Libre, M.D. 10400 Connecticut Avenue, Kensington, MD 20895 31. Dete filed (Month, Day, Year) 3 Registrer's Signeture State MAY 1 9 1998 July Savidson Randell Registrar

DHMH 16 Rev 6/95

Brown



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month John W. McCarthy 10:20 AM May 16, 1998 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | (Month, Day, Yeer) 7. Age (In yrs. last birthdey) 5. Sociel Security Number Birthplece (State or Foreign Country) Months 1₩ M 2□ F Yrs 520-03-0915 86 Aug. 4, 1911 Wyoming Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2€ No Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9901 Cedar Lane 20814 USA 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bieck, Whita, etc. 11. Maritel Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 1944-45 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 25t No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest greda complated) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Civil Engineer Private Contractors 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Byron McCarthy Lora Buholt 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Naoma C. McCarthy 9901 Cedar Lane, Bethesda, MD (wife) 20814 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 5/20/98 Alexandria, Virginia of Funeral Service Licensas 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 Perf. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? ral hematoma 3 Probably 4 Unknown 1 Yss 2 No 24b. Were autopsy tindings aveilebla prior to completion of causa of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

þ

Funeral

Director

7 is marked other than "netural", or items 23s or 28a-f show traumatic event, the Medical Examinat must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mental Hygiene. Important: if fleam 27 Is marked other than "natural", or Hema 23, any Injury or other traumatic event, the Medical Examination.

with the Merylend

Examiner physician and the buriel-transit

Box 68760.

Physician/Medical þ Completed Be 2 Certification: To the Hospital or Atterwithin 24 hours after der

27. Menner of Deeth

1 Naturel

2 Accident

3 Sulcide

4 Homicide

25. Wes cese reterred to medical examiner?

26. Piece of Deeth (Check only one) 1 Yes 2 No

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Dete of Injury (Month, Day Year)

Investigetion 6 Could not be determined

28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify)

3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signetura and titia of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number

Istert Disselles

May 6, 1998

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

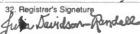
H. Robert Birschbach, 6320 Democracy Blvd., Bethesda, MD 20817 31. Dete tiled (Month, Day, Year)

State Registrar

Medical

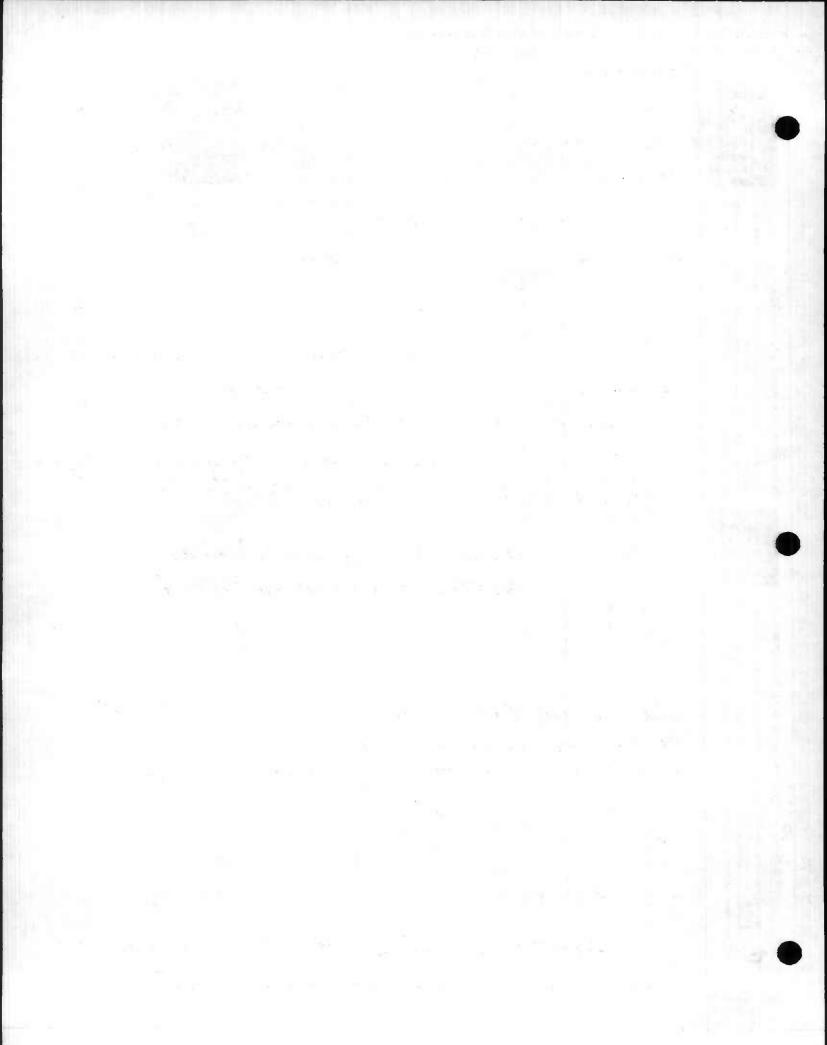
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5 Pending

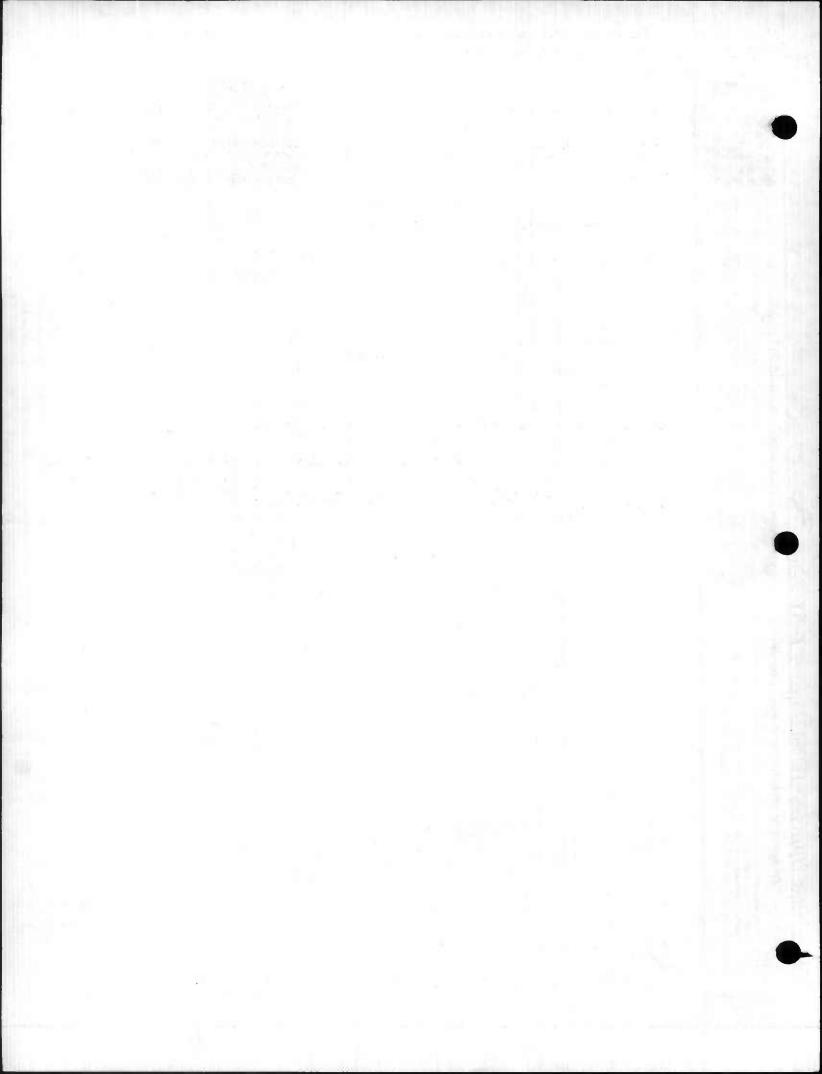


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or Attending Physician: after death. Director: After this certifica



						- Triangle				Death		Reg. No.	8	/ ()	197	
	Physici		W. Alexander									Dey 1998	Year		ne of Deeth	
	/Medic Examir		4a. Facility Name (If not Inst			ım <i>ber)</i>				4b. City, Town, or I	May 16 Location of Deal		ty of Death		10 111	
	LAGIIII		Suburban I	Hospit	a1					Bethesda	a	Montgomery				
	Funeral		5. Social Security Number	6. Se	×	7. Age (In yrs	. last birthde		der 1 Year	If Under 24 Hrs.	8. Date of Bi		1 70		ete or Foreign	
	Director		282-30-4198		□M 2ᡚF	68	Yrs.	Month	s Days	Hours Min.	April	2, 1930	Ol Ol	Birthpiece (State or Foreign Country) Ohio		
	dand ow		Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location											10d. Insid	de Cîty Limits	
Men	d 2 should be filed within 72 hours effer deeth with the Maryland and Mentale Hygiene. 7 is marked other than "natural", or liems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at	ctor	MD Montgomery Rockville											1 🗆	Yes 2 No	
	or 28	Director	10e. Street end Number 10f. Zip Code 10g. Citizen of W									Whet Cou	ntry?			
	eth w	rai	4306 Asper	n Hill	.1 Road 2					853			USA			
	er de	Funeral	11. Maritei Stetus		Armed Fo		J,S. 10	B. Was Dec	cedent of hoecify Cub	Hispanic Origin? (S en, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. Ra	ace - Ameri eck, White,		n,	
020	I'. or	by F	1 Never Married 2 ☐ 3 🖫 Widowed 4 🗆 Div		1 ☐ Yes If Yes, Gi Yeer or D	2 tyt No ive Detes:		1 🗆 Yes	2 No	Specify:		Spec	ify: A	sian		
2-0	2 hou		15. Dec	edent's Edu	cation			edent's Us			4.5	18b. Kind of				
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anc	if be fi		17. Fether's Neme (First, M							18. Mother's Ner		, Meiden Surni	ame)			
Maryland	should nd Me mark mark	2	Yee Moon I		(Type, Print) 19b. Meiling Address (Street					Wong		er City or Tow	wn State Zin Code)			
	od 2 :		Kerri L. Moy			ghter)			•							
Je,	othe othe		20e. Method of Disposition		(daughter) 10211 Duvawn Place 20b. Pleca of Disposition (Name of cemetery, cremetory or other place)						Dete		20c. Location - City or Town, State			
E .	t. Peges 1 and 2 thent of Health e tant: If item 27 is jury or other train		1 ☐ Buriel 2 🖫 Creme 4 ☐ Donetion 5 ☐ Oth			Stete	ropo1				18/98	Alexano	lria.	Virs	2inia	
<u></u>	permit. Peges Department of Important: If it any Injury or one		21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral													
Erring &	88 5 8		Home, Inc. 500 University Blvd. West Silver Spring, MD 20901													
9	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Fine) disease or condition resulting in deeth) Due to (or es e consequence of):											i Between		
5	requires that the death certificete be executed seen signed by the ettending physician and hould be detached for use as the burlei-transit	iner														
0-		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Anasarca Due to (or as a consequence of):													
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P.G	that the de ned by the detached	Phy									1□	1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknow				
Cords,	w requires to been signer should be	Completed by										24a. Wes en eutopsy performed? 24b. Were eutopsy available prior completion of			rior to	
F. B.	The law ate has b page 2 sl	ошь									1□	Yes 251 No		f deeth?	2□ No	
ta		Be C	25. Was case referred to m	edicai						26. Piece of Dea				03	10	
DAN 180	0 0	ToB	exeminer? 1 ☐ Yes 2 ☐ No	I	lospital:	inpatient 2	ER/Outpet	ient 3□ t	DOA Oth	her: 4 Nursing H			ther (Speci	ify)		
J. J.		on:		ending	28e. Dete (Mon	of injury th, Dey Year)	28b. Time Injury	,	28c. Injui Wo	ry at rk?		how injury occ				
Division	Attanding or death. Sector: After by the fune	cat	3 ☐ Suicide 6 ☐ C	ould not be	29a Plane	of Injune - At h	omo form	M street feets]Yes 2□No	28f Location	(Street and Nur	nher or Pur	re i Poute	Number	
	or Attand efter death Director: d in by the	Certification:	4 ☐ Homicide d	etermined	buildi	e of injury - At h ing, etc. (Speci	ify)	street, tect	ory, onice			wn, Stete)	nber or Hur	er House	rvunt <i>ber</i> ,	
3	Hospita 24 hours Funeral stely fille	edical C	29e. Certifier 11 Car (Check only one) 2 Med	rtifying Phy- dicat Exami	ner: On the b	best of my kno asls of exemina ner steted.	owledge, de etion end/or	eth occurre investigation	ed et the tir on, in my c	me, dete end plece opinion, deeth occu	, end due to the rred at the time,	cause(s) end a dete end plece	manner as a	steted. to the cau	180(s)	
	To the within 2 To the comple	Me	29b. Signature and title of cartifier 29c. License number									29d. Date sign	ned (Month,	Dey, Ye	ar)	
-	6		Mul	Much A Horder MS D47791								May 1	8, 19	98		
V	_		30. Name end eddress of pe													
			David A. Hol					11 Ro	ad, I	Rockville	, MD 2	0851				
	Sta	te		0 100	10	egistrer's Sign	In-A-Ray	nde 82								



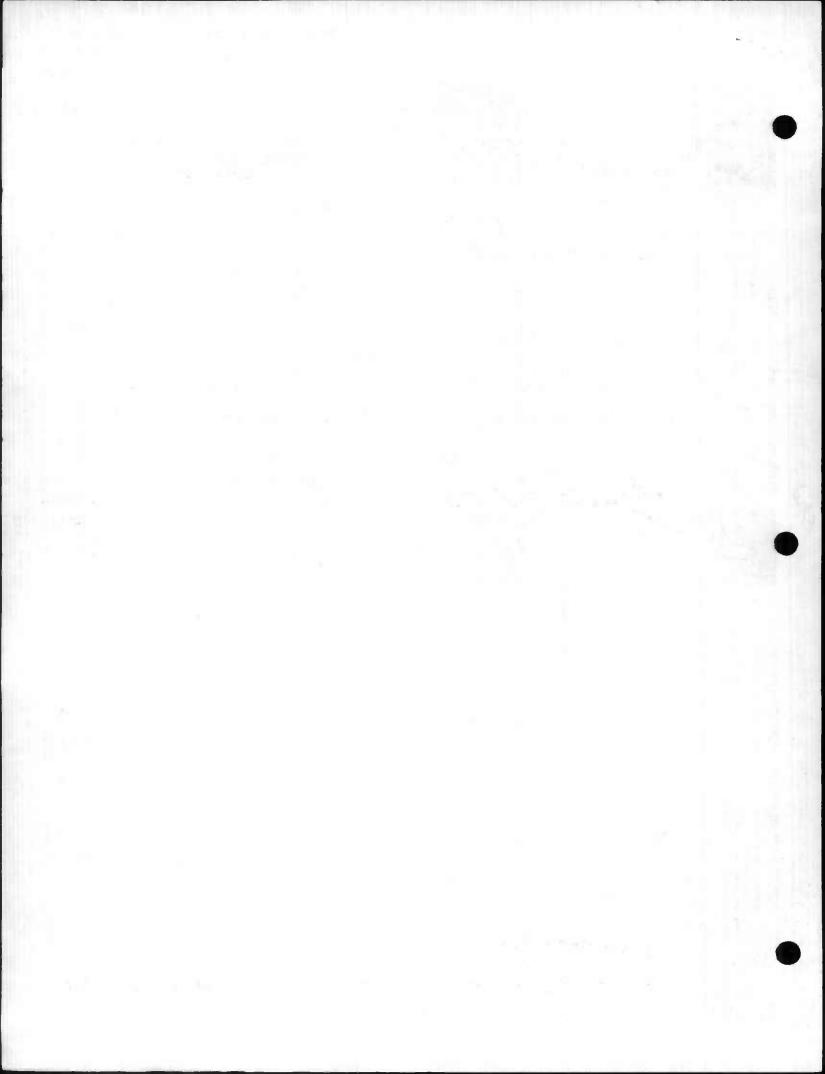
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month George McDonald 1998 9:25 A.M. May /Medical 4a. Fecility Nama (If not institution, give straet end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Manor Care Health Services Silver Spring Montgomery If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Soctal Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Deys 1₩ 2□ F 037 16 6830 Yrs 73 Director July 8,1924 Providence, RI. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is merked other than "natural", or items 23a or 28a-f show any filtury or other treumatic event, the Medical Examination. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A N/A Director 1 ▼ Yas 2 No Washington, D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 723 E. Capitol St., S.E. 20003 United States Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yas, Give Yaar or Detes: WW2 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 Divorcad White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) George McDonald Laura B. Creegan 2 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) George Palmisano (Nephew) 11 Harris Rd., Moosup, Connecticut 06354 20b. Placa of Disposition (Nema of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 In Crametion 3 ☐ Removel from Stata Chesapeake Crematory Inc. 5/15/98 Beltsville, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature Funeral Service Licenset 22. Name and Address of Facility
MCGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington, D.C. 20012 tack 23a. Park Epfer tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, fock, or heart feiture. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical gastric cancer 6 months Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es a consequence of): physician ar a the burial-t Box 68760. Physician/Medical Due to (or es e consequença of) ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? Signed by 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings avelleble prior to complation of cause of death? 24e. Wes en eutopsy performed? Completed 1 Yas 2 No certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatiant 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Naturet 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral C 29a. Certifier (Check only one) 12 Cartifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the I within 2 To the I complet 29b. Signature end title of certifier 29c. Licanse number 29d. Dete signad (Month, Dey, Year) 043237 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Paul Armstrong, M.D., 14201 Laurel Park Dr. Ste. #102, Laurel, Maryland 20707 31. Dete filed (Month, Dey, Year)

State Registrar

MAY 1 8 1998

32. Registrer's Signature This Davidson-Randell



iclan end burial-transit

physician s the burial

attending

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this funeral Physician/Medical

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Completed

Be

10

Certification:

Medical

Box 68760.

P.O.

Records,

Division of Vital

Attending

deeth.

aftar deeth Director:

To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

2+

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death Month May 15, 1998 1:50p 4b. Cify, Town, or Location of Deeth 4c. County of Death HYATTSVILLE PRINCE GEORGES

4203 UNDERWOOD STREET 5. Social Security Number

7. Age (In vrs. last birthday) 150 M 2□ F Months Deys 72 Yrs. 171-24-3099 Usual Residence of Decedent

8. Dete of Birth (Month, Day, Yeer) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Hours Sept. 23, 1925 Pennsylvania

10h County 10c. City. Town or Location Prince Georges University Park

1 ☐ Yes 2 1 No 10f. Zip Code 10g. Citizen of What Country?

4203 Underwood Street

Robert S. Medwith

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWI] WWII

(wife)

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

20782

14. Race - American Indian, Bleck, White, etc White

10d. Inside City Limits

15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

USA

12 17. Fether's Name (First, Middle, Last)

Plumber Plumbing 18. Mother's Neme (First, Middle, Maiden Sumame)

Agnes Unknown

Joseph Medwith

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

Mary Kay Medwith 20a. Method of Disposition

20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Metropolitan Crematory

4203 Underwood Street, University Park, MD Date 20c. Location - City or Town, Stete

21. Signature of Funeral Service Licensee

5/19/98 Alexandria, Virginia Francis J. Collins Funeral 22. Name end Address of Fecility 500 University Blvd. West Home, Inc.

low 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

20901 Silver Spring, MD Approximete Interval Between Onset end Death

Intraoral Gunshot

Due to (or as a consequence of)

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

Due to (or es e consequence of):

Due to (or es e consequence of):

23b. Did tobacco use contribute to the cause of death?

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy Limited 1. Yes 2 □ No 24b. Were eutopsy findings available prior to completion of ceuse of death? 1 Yes 2 No

25. Was cese referred to medicel 1 Xes 2 No

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

27. Menner of Death 1 Netural 2 Accident 3 Suicide

4 Homicide

28e. Date of injury (Month, Day Year) 5 Pending investigation 5-15-98 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2.2 No unknown

Self in flicted gunshet wound 28t. Location (Street end Number or Hural Route Number, City or Town, Stete) 4203 underwood St.

29a. Certifier (Check only one)

Residence Hyatsville, Maryland 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner as steted.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E.

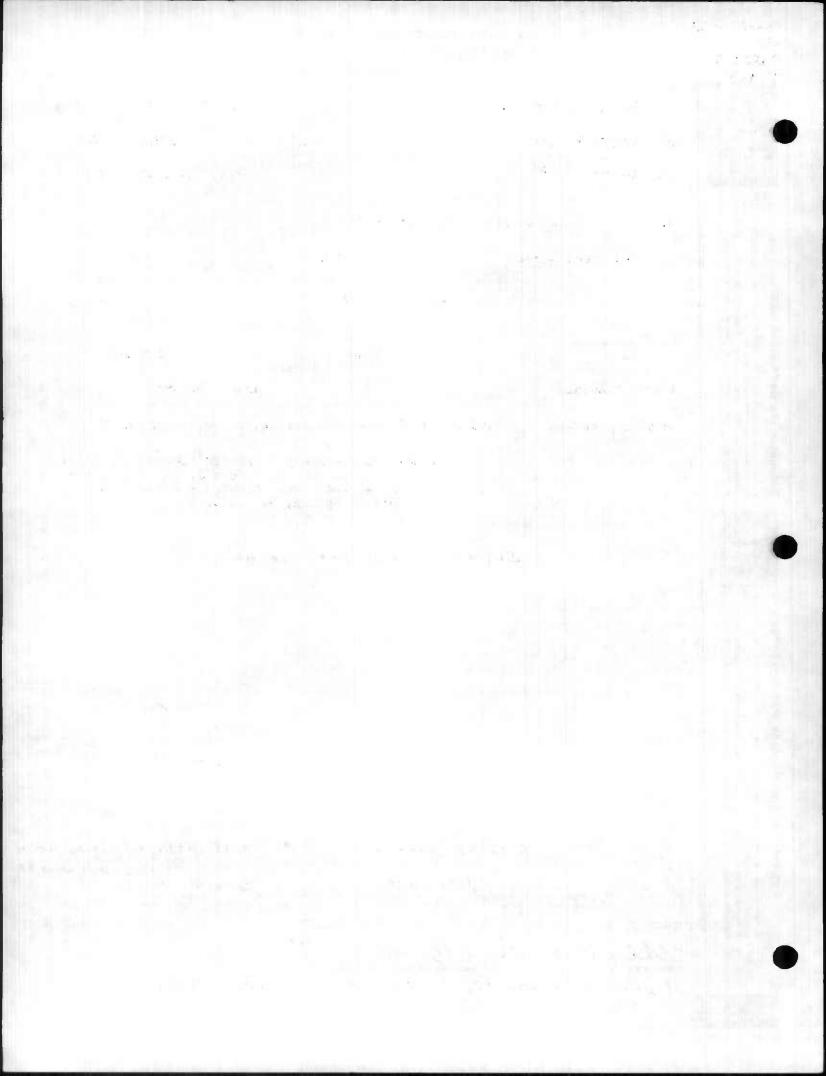
29d. Date signed (Month, Day, Year) May 16, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Radentz 111 Penn Street, Baltimore, Maryland 21201

State

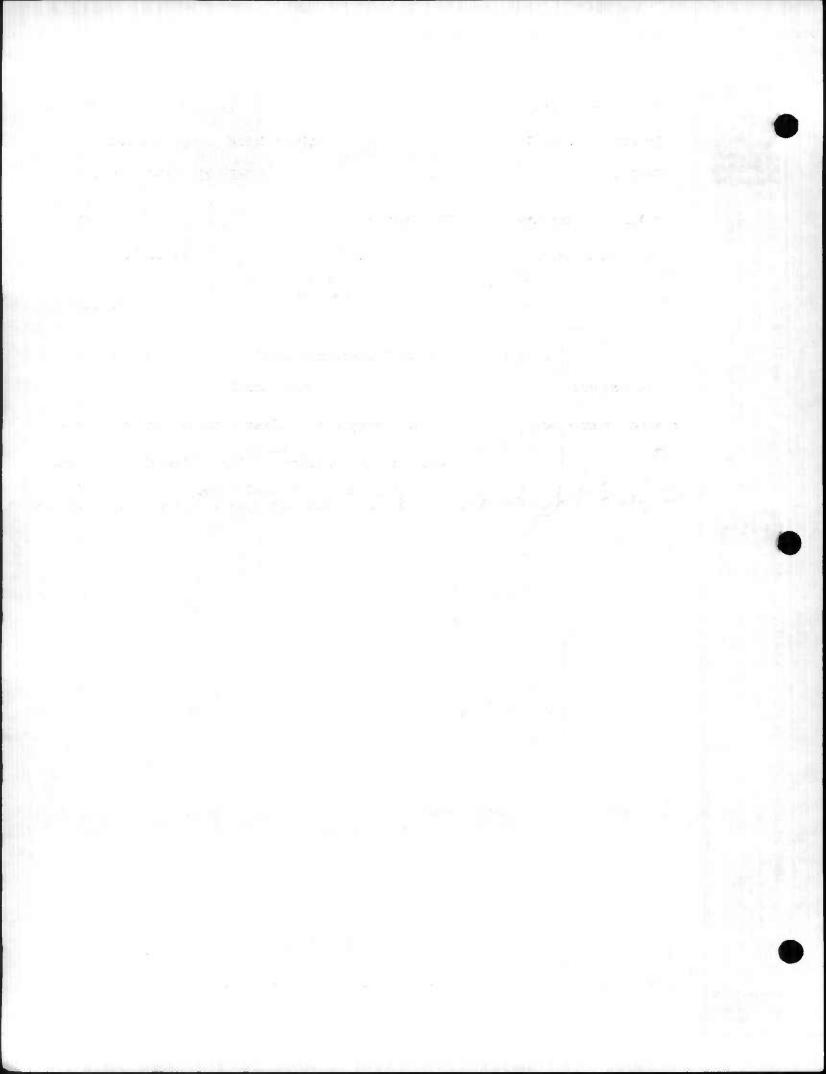
Registrar



State of Maryland / Department of Health and Mental Hygiene 98

						Certificate of	of Death	F	Reg. No.				
	Physic		1. Decedent's Neme (First, Middle, La Emma Lampert Me	•				2. Dete of Dea Month May 15	afh	Yeer	3. Time of Death		
d	/Medi		4e. Facility Neme (If not institution, gi	ve street and number	r)	4b. City. Town, or	Location of Death		of Death	04.20am			
1	Exami	ner	Holy Cross Hosp		7		Silver S			gome	r37		
Н	Funeral				ge (In yrs. last bir		ar If Under 24 Hr			9. Birthi	plece (State or Foreign		
	Director		060-03-9166 Usuel Residence of Decedent	6. Sex 1 Months 1 Months 1 Min. 1 Months 1 Min. 1 Min									
	death with the Maryland rms 23e or 28e-f show r must be notified at		10a. Stete 10b. County					10d. Inside City Limits					
		Ş	Maryland Montg	omery	Silver	Spring			XX Yes 2□				
	5 to 6 to	Director	10e. Street end Number			10f. Zlp Cod	θ		10g. Citizen of	Whet Cou	ntry?		
	020 urs ather death with the Marylar at, or thems 23a or 28a-f ahor Examiner must be notified at		1315 Fenwick La	ne		2091	10		U. S. A.				
		Funeral	11. Merifel Sfetus	12. Was Deceder Armed Forces		13. Wes Decedent of	of Hispenic Origin? (Juben, Mexican, Pue	Specify Yes or No-		e - Americk, White,	can Indien,		
21215-0020		by	1 ☐ Never Married 2 ☐ Married XXX Widowed 4 ☐ Divorcad	1 ☐ Yes 20 If Yes, Give Yeer or Detes	(No	1□Yes 2∏		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify		ite		
5	22 불념	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usuel Oc (Give kind of work do.	ne during most of wo	orkina	16b. Kind of B	usiness/în	dustry		
121	filed within Hygiene. ther then "	Jq.	Elementery/Secondary (0-12)	College (1-4o		life. DO NOT use ret	ired)						
72	Hody Hygie Hert Mr. ID		17 Fallanda Nama (Fina Adida). 1	3 Years	Spe	cial Educa		-	New Yo		tate		
Maryland	2 G E E	Be	17. Fether's Neme (First, Middle, Last)		eme (First, Middle,	Maiden Suman	10)					
ž	should and Men marks umarks	2	Isaac Lampert				Rose Pe						
Mai	Mar 2 sho 1 smd 1 smd		19e. Informent's Neme/Relationship			. Melling Address (Stre							
	l and teath m 27 her te		Eugene Meyer -	Son		2 Harvey F							
jor	Pages sent of h nut: If its ary or of		20a. Method of Disposition 1 ∰urial 2 ☐ Cremation	Removal from SMI	cemeter	Disposition (Neme of y, cremetory or other p	olace) May	17 1998	20c. Location -	City or To	own, Stele		
븚	Baltimore, permit. Pages 1 a Department of Hea important: If them any injury or othe gase.		4 Donation 5 □ Other (Syllo)		Mount	Lebanon Ce	emetery	1998	Glendal	e, N	ew York		
Bal			21. Signature of Funeral Service Lics	nsee /	/	22. Name end Ad	dress of Fecility Son Funer				22046		
_	0.0240		Tacuna N	Nenda	Su-	472 N. Wa	shington	Street.	Falls C	hurcl	h, Virginia		
	Physician	(23a Pert1 Eme the disease, or con shock or he d feiture. List only	one ceuse on each	ed the deeth. Do r line.	nof enter the mode of o	dying, such es cardia	ac or respiretory en	rest,		Approximete Intervel Between		
											Onsef end Deeth		
	/Medical Examiner		Immediate Cases (Finel Illustrate r condition resulting in deeth)	· caro	liac ar	consequence ot):	a						
			resulting in deeth)	1	Due to (or es e	consequence ot):			_	1			
	erit sit	line		hype	1 kalen	ua				1			
68760,	the death certificate be executed by the attending physician and sched for use as the burial-transit	i Examiner											
876	sate b	edical	thet initiated events resulting in deeth) Lest										
×	entific ding p	≥	Phababayolys's										
Bo	ath c	Physician/											
0	the day	ysle	Pert fl. Other significant conditions of	_			given in Pert I.	23b. Did to	obacco use go	ntribute t	o the cause of death?		
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200	been s	Completed	Tight opport	ارا مور	O / D CO	-49		perfor	med?	ev	relieble prior to empletion of cause		
Re		du.							/	ot	deeth?		
a	ilclan: The lav certificate has rector, page 2							1□Y	es 2 No	1[☐ Yes 2☐ No		
Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospitel:	/		Othor		eth (Check only one)				
o	this sel di	To.	1 ☐ Yes 2 ☐ No 27. Menner of Deeth	1 Infpai		perior 30 DOX		Home 5 Resid			(y)		
	ding h. After fune	Certification:	1 ⊠Netural 5 ☐ Pending	28e. Dete of In (Month, D	ay Year) 28b. T		njury et Vork? □ Yes 2 □ No	28d. Describe h	ow injury occur	red			
<u>S</u>	Attending r death. ector: After by the fune	Ica	3 ☐ Suicide 6 ☐ Could not b	e Ogo Diogo of In	nium. Al homo for	rm, street, fectory, offic	1100001 - 01	28f Location (S	treat and Numb	or or Pun	al Route Number.		
Division	or Attendation of the or Attendation of the order of the	erti	4 ☐ Homicide determined	building,	itc. (Specify)	im, street, rectory, orni	29	City or Tow		er or riure	ii Houte Wallber,		
_	pspital hours uneral ly filled		29a. Certifier 1 Certifying Pt	veicing: To the hee	of my knowledge	, deeth occurred et the	time data and place	o and due to the e	seuso/o) and me	ND 04 00 0	teted		
	P Hos 24 h Fun etely	edical		niner: On the basis	of exemination and	Vor investigetion, in m	y opinion, deeth occ	urred et the time, d	dete end plece,	end due to	o the ceuse(s)		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature end title of certifier	^		29c. Lice	ense number	2	29d. Date signe	d (Month,	Dey, Year)		
1			107	81-	MI	D	41341						
	D		30. Neme end address of person who	Tripleted serves -4	death (from 325)				May 15,	1998			
			V 1001 / 16.	opriipieted cause pr		Georgia A	ve.Silver	Spring N	Md 2091	0			
	Sta	ite	31. Dete filed (Month, Day, Year)	32 Regis	trar's Signeture			ahrrug I	2071	~			
	Registr	ar	MAY 1 8 199	8 guar	Davidson-R	indell							

DHMH 16 Rev 6/95

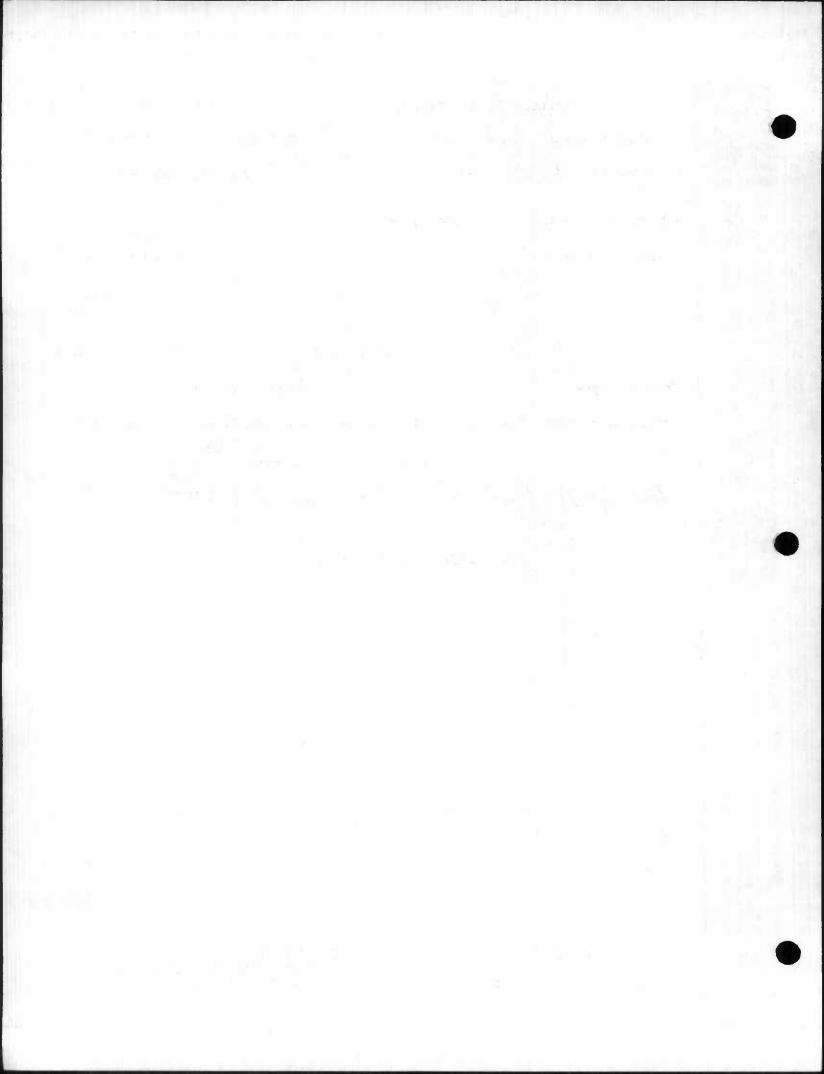


State of Maryland / Department of Health and Mental Hygiene 9 8 7 0 | Certificate of Death

						Cer	tificate	of Death		Reg. No.					
	Physic	ian_	Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Ye												
4	/Medi	cal				MURPHI		Ab Ch. Taum as	MAY						
7	Examii	ner	4e. Fecility Name (If not institution NATIONAL NA	VAL MEDICA	L CENTI			ВЕТНІ	rh, or Location of Deeth THESDA 4c. County of Death MONTGOMERY						
	Funeral Director		5. Sociel Security Number 418-62-3270 G. Sex 1 Months 90 H. Under 1 Yeer If Under 24 Hrs. 8. Date of Bit (Month), Days Hours Min. May 10								Year) 9. Birthplece (Stete or Foreig Country) Pennsylvania				
	Wend we		10a. State 10b. County 10c. City, Town or Location												
	Man H	to	Maryland Montgomery Rockville									1 ☐ Yes 2X No			
	or 284	lrec	10e. Street end Number 10f. Zip Code 10g. Citizen of V									ntry?			
	ih wii	Je.	12126 Gaynor F	52		United	Stat	es							
020	72 hours effer death with the Marylend natural, or Items 23a or 28a-f show Jical Examiner must be notified at	by Funeral Directo	11. Maritel Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed Formied 1 Tes	1 ☐ Yes 2 ☑ No			of Hispanic Origin? (: Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)		ca - Americack, White, by: White				
21215-0020	permit. Peges 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturat", any injury or other traumatic avent, the Medical Exp. 2010.	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12)		e completed) (Give kind life. DO N			one during most of wo etired)	orking	16b. Kind of B					
	filed v Hygie Ither t	ပိ	17. Fether's Name (First, Middle	4 (est)			SOCIAL	Worker	mo /First Middle			w York			
an	Mental Merked of	o Be	Francis Joyce	et Billm	First, Middle, Melden Sumame)										
Baltimore, Maryland	2 should and Men Is marks aumatic	2	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (St			mber, City or Town, State, Zip Code)					
	1 and 2 Heelth e		Frances M. Pres	ston /Daug	hter			Road, Ro							
	of He		20e. Method of Disposition	2 Dameur Liver		Ptaca of Dispos	sition (Name of	of place) May	22, Date 1998	20c. Location	- City or To	wn, State			
	Peges ment of ant: If its ury or o		1 ☑ Buriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Mitchell National Cemetery Seale, Alaba									.ma			
Ball	permit. Peg Department Important: h any Injury o		21. Signature of Funeral Servica Licansee M00831 22. Name end Address of Facility Robert A. Pumphrey Fundamental Rockville, Inc. 300 West Montgomery Rockville, Maryland 20850												
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications thet c t only one ceuse on e	aused the death					rrest,		Approximate Interval Between			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a. CC	NGESTIV	/E HEAR		URE				Onset end Death			
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	and and I-trans		Sequentially list conditions, The desired of the sequence of												
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68760,	eath certificete be executed attending physician and for use es the buriel-transit	Medical													
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	0 0 0	Physician	Part II. Other significant conditi	ona contributing to de	ath but not resu	uiting in the un	derlying caus	e given in Part I.	23b. Did t	tobacco use co	ontribute to	the cause of death?			
P.0	d by t										2 No 3 Probably 4 Munknown				
Records,	requires thet the een signed by th hould be deteche	d by							24e Wes	an autopsy	24h W	ere autopsy findings			
COL	> 10 0	Completed			-				perfo	rmed?	av	ailable prior to mpletion of cause death?			
Re	iclan: The law certificate hes b rector, pege 2 s	ошо							101	res 2X No		Yes 2□ No			
Vital	an: T tificat tor, p	Be C	25. Was case referred to medical	al				26. Place of De	eath (Check only o			3163 2010			
₹ V	5 m	ToE	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 🗆 I	npatient 2	ER/Outpatient	3□ DOA	Other:	Home 5 ☐ Resid		ner (Specif	y)			
ion of	Attending Ph r deeth. ector: After th by the funeral		E LI / louidoill	igation	of Injury h, Day Year)	28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	d. Describe how injury occurred					
Division	tal or Attendi rs efter deeth al Director: A ed in by the f	Certification:	3 Suicide 6 Could 4 Homicide deterr	6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street end Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: Affer th completely filled in by the funeral	edicai	29a. Certifier 1 Certifyli (Check only 2 Medical	ng Physician: To the Examiner: On the ba and mann	isis of examinat	wiedge, death tion end/or inv	occurred at the estigetion, In r	e time, date and plac ny opinion, death occ	a, and due to the durred at the time,	cause(s) and m date and place,	anner as st and due to	lated. the cause(s)			
	To the To the Com	Σ	29b. Signature and title of christia	N.			29c. Lk	cense number		29d. Dete signe	d (Month,	Day, Year)			
	24		· 414	ND				39397 (WI)		May 14, 98					
			30. Name end address at berson			23a) (Type, F	Print) N	ATIONAL NA	AVAL MEDI		ITER				
			S.J.CASH,	LT, MC, US	N		В	BETHESDA MD 20889-5600							

State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey **Physician** :48 Pm PAUL MAY 11, 1998 LESTER May /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick
If Under 24 Hrs. Frederick 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1₽M 2□ F Days Months Hours Min. Yrs. 86 Director 214-10-3382 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Haalth end Mental Hypiene. Important: If item 27 is marked other than "nature!, or items 23s or 28s-4 show any injury or other traumatic event, the Mexical Examiner must be notified any. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 12 Yes 2 No Directo Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8514 Fountain Rock Court 21793 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white g 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Blue Ridge Elementary/Secondery (0-12) College (1-4or 5+) Sales Representative Oil Company 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) John William May Grace Bohn May 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Nancy Baker / daughter 8514 Fountain Rock Ct., Walkersville, MD 21793 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Garden 5/15/98 Frederick, Maryland 22. Name and Address of Facility
Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD not enter the mode of dying, such as cardiac or respiratory arrest. 21702 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) Pulmonery Examiner Due to (or as e consequence of): Examine neumonia physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence ot): 200 950 signed by the a d be detached t 23b. Dtd tobacco use contributs to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? should l 24a. Was an autopsy performed? Completed cartificate has b 1 Yes 2 No 1 Yes 22 No To the Hospital or Attanding Physician: within 24 hours aftar death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, 25. Was case reterred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1☑Inpatient 2□ER/Outpatlent 3□ DOA 28e. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai and manner stated. 29d. Date algned (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 4161 May 13, 1998

310

Walkersville, MB 21793

State Registrar 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

32 Registrer's Signature

AM AM

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Daeth 3. Time of Death Day **Physician** 4b. City, Town, or Location of Death 1998 4c. County of Death /Medical Juanita Eleanor Miller 8:00 a.m. 4a. Facility Nema (If not institution, giva street and nur Examiner Cumber 24 hrs. 8. Data of Birth Min. 8. Mata of Birth (Month, Day, Year) Devlin Manor Nursing Home Allegany 9. Bahplaca (Stata or Foraign Country) if Under 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Yrs Director 213-22-4414 88 Dec 29, 1909 MD Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits traumatic event, the Medical Examiner naunt be notified at Director 1 Yas 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò Items 23a 229 Baltimore Avenue Funeral 21502

13. Was Dacedent of Hispanic Origin? (Specify Yes or NoIf Yas, specify Cuben, Maxican, Puarto Ricen, etc.) 14. Hace - Amarican Indien, 12. Wes Decedant Evar in U,S. Armad Forces? pernit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health end Mental Hygiene. Important: if Itam 27 is marked other than "naturel", or the any Injury or other traumatic event, tra Medical Evantine and Injury or other traumatic event, traumatic event, process Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No if Yas, GiveX Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à Specify: 3. Widowed 4 □ Divorcad Year or Datas 16b. Kind of Businass/Industry Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Former Employee
18. Mothar'a Nama (First, Middla, Maidan Sumama) 12 Textile 17. Fathar's Nama (First, Middla, Last) Be Charles H. Sharon Emma Grace (Rockwell)

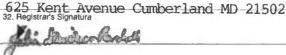
19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raletionship (Type, Print) Ray O. Miller-son 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 05/23 Cumberland MD 21. Signatura of Funeral Sorvice License 22. Nama end Address of Facility Scarpelli Funeral Home, P.A. cons that caused the death. Do not antar the mode of dying, such as cerdiac or raspiratory arrast, 23a. Pert1. En ar tha diseese, or complications that caus shock, or haart failure. List only one cause on each Approximata Intarval Between Onsat end Deeth **Physiclan** /Medical Immadiata Causa (Finel disease or condition rasulting in daath) Examiner Due to for as e consequance of): Examiner sician and burial-transit Sequantially list conditions, if any, laading to Immadiata ceusa. Enter Underlying Cause (Diseasa or Injury that initieted avents resulting in daath) Last Dua to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Dua to (or es e consequance of): P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown sate has been signed, page 2 should be dei Records, Q Be Completed 24e. Wes an autopsy performed? 24b. Were autopsy findings evailabla prior to complation of cause of deeth? certificate has 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physicien: director. 25. Wes casa rafarred to medical 26. Piace of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Othar: 4 Nursing Home 5 Rasidance 8 Othar (Specify) Certification: To this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Yaar) 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? Affer 5 Panding invastigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) in by 4 - Homloida Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) end manner as stated.

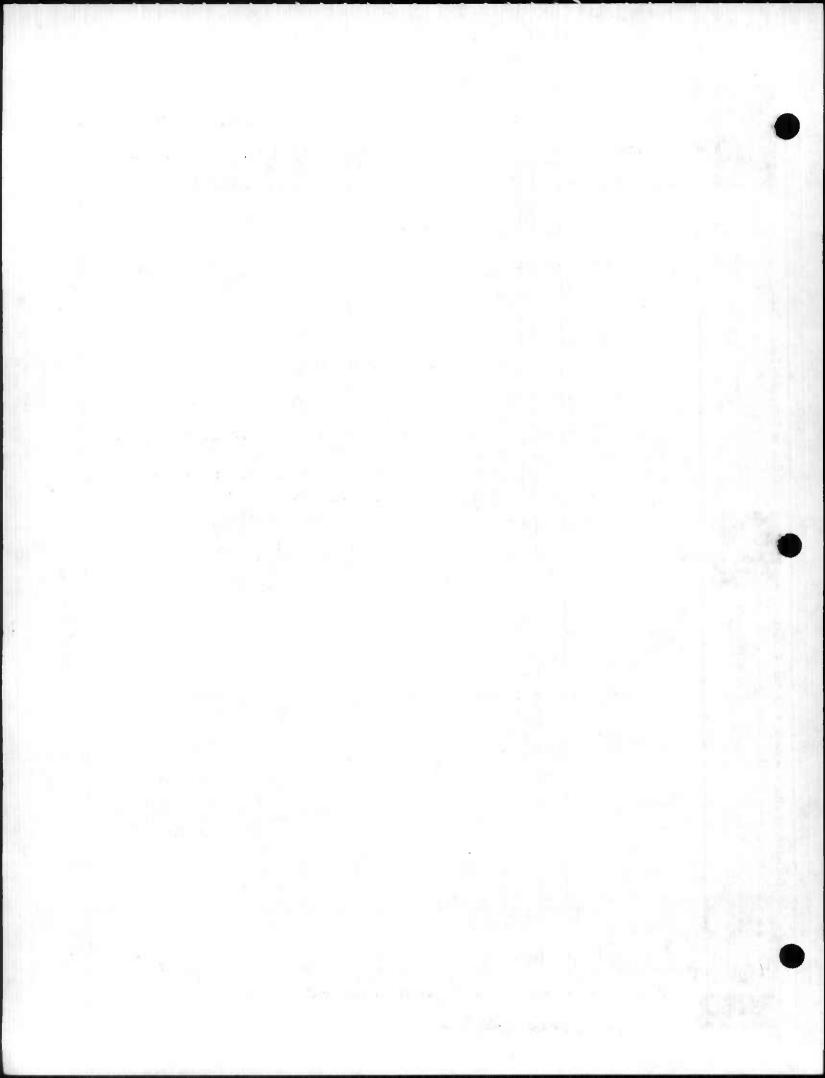
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifiar To the Hosp within 24 hor To the Fune completely fi Medical 29b. Signetura and titla of partif 29c. Licansa number 29d. Date signed (Month, Day, Year) D33280 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

State Registrar

MAY 2 6 1998

Dr. Sunil K. Gupta
31. Data filed (Month, Day, Year)





State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** Mildred Ilene Minnick 7:13 A.M. 1998 May /Medical 4a. Fecility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Deeth Examiner Allegany 11611 Dobbin Drive Frostburg 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) Funeral 8. Date of Birth (Month, Dey, Year) Deys 1 □ M 2 🖾 F Months Hours 213-22-3488 83 Yrs. Director 26-Aug-14 Maryland Usuel Residence of Decedent filed within 72 hours efter death with the Maryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Allegany Frostburg 10e. Street and Number 11611 Dobbin Drive 10f, Zlp Code 10g. Citizen of Whet Country? ŏ Items 23a 21532-U.S.A. Completed by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritai Status 1 □ Never Married 2 □ Married 21215-0020 ò 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "naturel", 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit, Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic evenance." Elementery/Secondery (0-12) College (1-4or 5+) Housekeeper Motel Housekeeping 8 Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be **Leroy Jefferies** Grace Virginia Michaels 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Raymond Minnick 11603 Dobbin Drive Frostburg Maryland 21532-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete 23-May-98 4 ☐ Donation 5 ☐ Other (Specify) Saint Michael's Parish Cemetery Frostburg, Maryland 21. Signature of Funerel Service License 22. Name and Address of Facility ohn Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 239 Part 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. **Physician** acute Myocardual Infarchin /Medicai Immediate Cause (Final disease or condition resulting in deeth) Examiner Coverney Atherosclereis The law requires that the death certificate be executed the burief-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Box 68760, ed by the ettending physician deteched for use as the burie Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. heart Failure. Hyperlin Som 1 Yes 2 No 3 Probably 4 Unknown Completed by Diality millety 24b. Were autopsy findings available prior to completion of cause ot death? 24e. Was an eutopsy performed? 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No ial or Attending Physician: The ster death.

Is effer death.

In Director: After this certificate ed in by the funeral director, pa 26. Place of Deeth (Check only one) Be 25. Wes case referred of medical exeminer? Other: 4 Nursing Home 5 MResidenca 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 20 No 1 Yes 27. Manney of Deeth Certification: 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 11 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifin 4464 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Yeer) MAY 261998 32. Registrer's Signature

S. L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, Maryland 21532

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Nama (First Middle Last) 2. Deta of Death **Physician** Month 1998 06:50 AM Margaret Virginia Jeffries Monahan May /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 178 Mount Pleasant Street Frostburg If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1 M 2 K F 217-18-4487 74 Yrs. 22-Mar-24 Maryland Director Usuel Rasidanca of Dacadant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show ir than "naturel", or Items 23a or 28a-f ehov the Medical Examiner must be notified at 1 Yas 2 No Director Allegany Maryland Frostburg 10e. Street and Number 178 Mount Pleasant Street 10f. Zip Coda 10g. Citizan of Whet Country? 21532-U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygians, inter if them 22 inter it if them 22 is marked other than "naturel", or them 23 inty or other traumatic event, the Medical Exertice mustry or other traumatic event, the Medical Exertice must Funeral 12. Was Dacadant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yas 2 No If Yas, Give Yeer or Datas: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Sales person cosmetics 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be George Buskirk Mary Crawford 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Thomas P. Monahan 69 Tarragon Lane Maryland 21037-Edgewater 20a. Mathod ot Disposition 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from State Department of Important: If eny injury or once. 25-May-98 Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 21. Signature of Funaral Service I 22. Nama and Addrass of Facility bohn 1 urs Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 231 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only one cause on each line. Onset and Death Physician /Medical Immadiata Cause (Final diseesa or condition resulting In death) VALVULAR HEART BESEASE TEN YEARS Examiner Due to (or es a consequenca ot): Physician/Medical Examiner ician and bunal-transit Sequentielly list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in daath) Last Due to (or es e consequença ot) Box 68760. tha Due to (or es e consequenca ot): P.O. signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown CHRONIC URSTRUCTIVE LUNG DISEASE Division of Vital Records, þ 24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed CONCESTIVE HEART FAILURE paga 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifical ttaly filled in by the funeral director, Be 25. Wes case retarred to medical axaminar? 28. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Tyas 2 No 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 1 Natural 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicida 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 28a. Placa of Injury - At home, tarm, street, tectory, offica building, etc. (Specify) 4 Homicide 24 hours a edical 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil 29a, Cartifiar 29d. Data signed (Month, Day, Year) 29b. Signatura end title of certifier 29c. License number March MAY, 26, 1998 1 26907 Nama and address of person who complated cause of death (Item 23a) (Type, Print)
 Jarjit S. Sldhu, M.D., 925 Bishop Walsh Road, Cumberland, Maryland 21502 31. Data tiled (Month, Dey, Yeer) State MAY 2 6 1998 Registrar

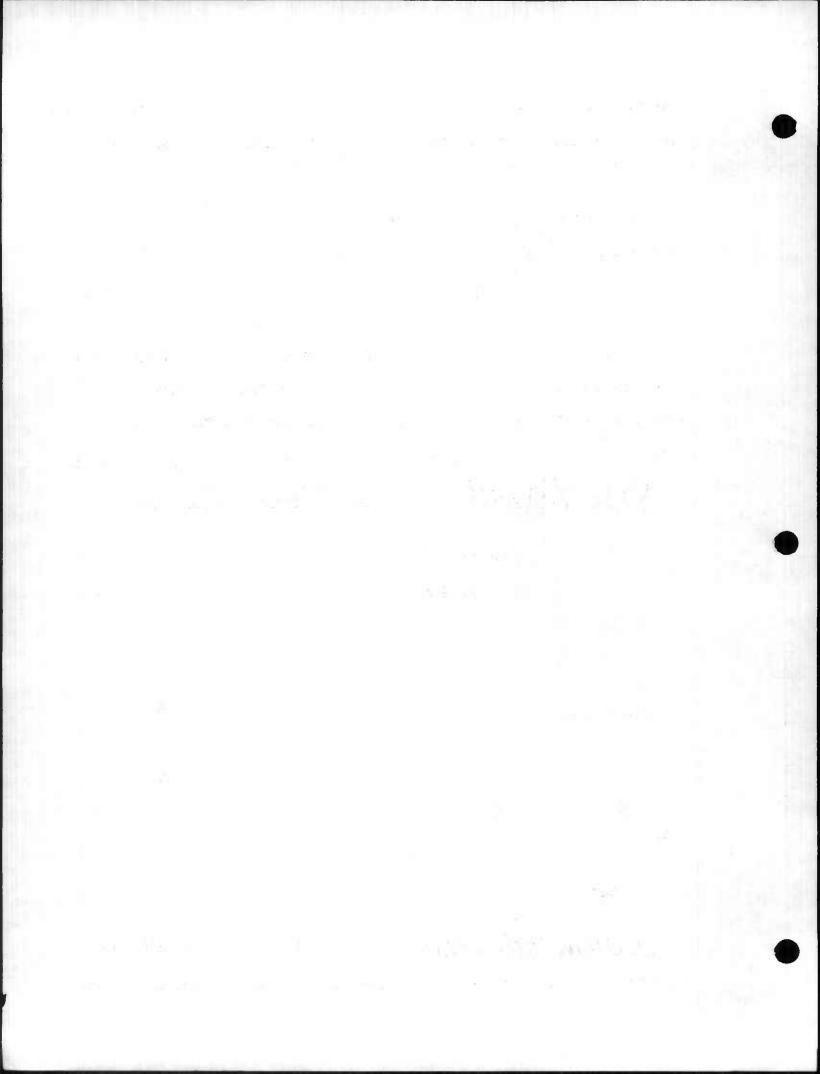
A Real of State of the State of

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yaar **Physician** OLLIE FRANCES MORRISON 14:15 PM MAY 22 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY H Under 24 Hrs. 8. Date of Birth (Month, Day, 1913) 5. Social Sacurity Number If Undar 1 Yaar 9. Birthplace (State or Foreign Country)
W • VA • 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕏 F 220-58-0615 84 Yrs. Director Usual Residence of Dacedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yas 2 No Director MARYLAND ALLEGANY MT. SAVAGE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 15501 MT. SAVAGE ROAD 21545 U.S.A. items 23s Funeral 12. Was Decadanf Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner 1 Never Married 2 Married 21215-0020 ò 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ond Mental Hygiene. is marked other than Elemantary/Secondary (0-12) College (1-4or 5+) 12 HOUSE KEEPER HOUSE KEEPER Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Pages 1 and 2 should be LUTHER O'NEAL EVANS MATILDA MATTHEWS 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 Department of Health e Important: If flem 27 is any injury or other trai KENNETH L. MORRISON SR P.O.BOX#361 SON MT. SAVAGE MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) REST LAWN CEMETERY MAY 26 1998 LAVALE, MARYLAND ature of Funaral Service Lic 22. Nama and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 0 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final RENAL FAILURE disaase or condition rasulting in daath) 2 YEARS **Examiner** Due to (or as e consequence of): Examiner DIABETES MELLITUS 30 YEARS The law requires that the death certificate be executed the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disaase or Injury that initiated evants resulting in daath) Last and Dua to (or as a consequence of): OLLIE MORRISON 220-58-0615 Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or as a consequence of): detached Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I, 23b. Did tobacco use contribute to the cause of death? the been signed by should be detac 1 Yes 2 No 3 Probably 4 ☐ Unknown CARDIOMYOPATHY p 24b. Ware autopsy findings available prior to director, page 2 should Completed 24a. Was an autopsy performed? completion of ceuse of death? this certificate hes 2 No 1 Yas 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica Be 25. Was casa referred to medice 26. Place of Death (Check only one) axaminar? Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatiant 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No In by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida To the Hospital or within 24 hours eft To the Funeral Di completely filled in 29a Certifier Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Scarning Physician: To the basis of ny knowledge, death occurred at the time, date and place, and due to the causa(s) and manner stated.

2 ☐ Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 cern (VV) D 16041 1998 M55 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) DR. TERRY WILLIAMS, MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD 31. Date filed (Month, Day, Year)
MAY 2 6 1998 21502 32. Registrar's Signature State

Registrar

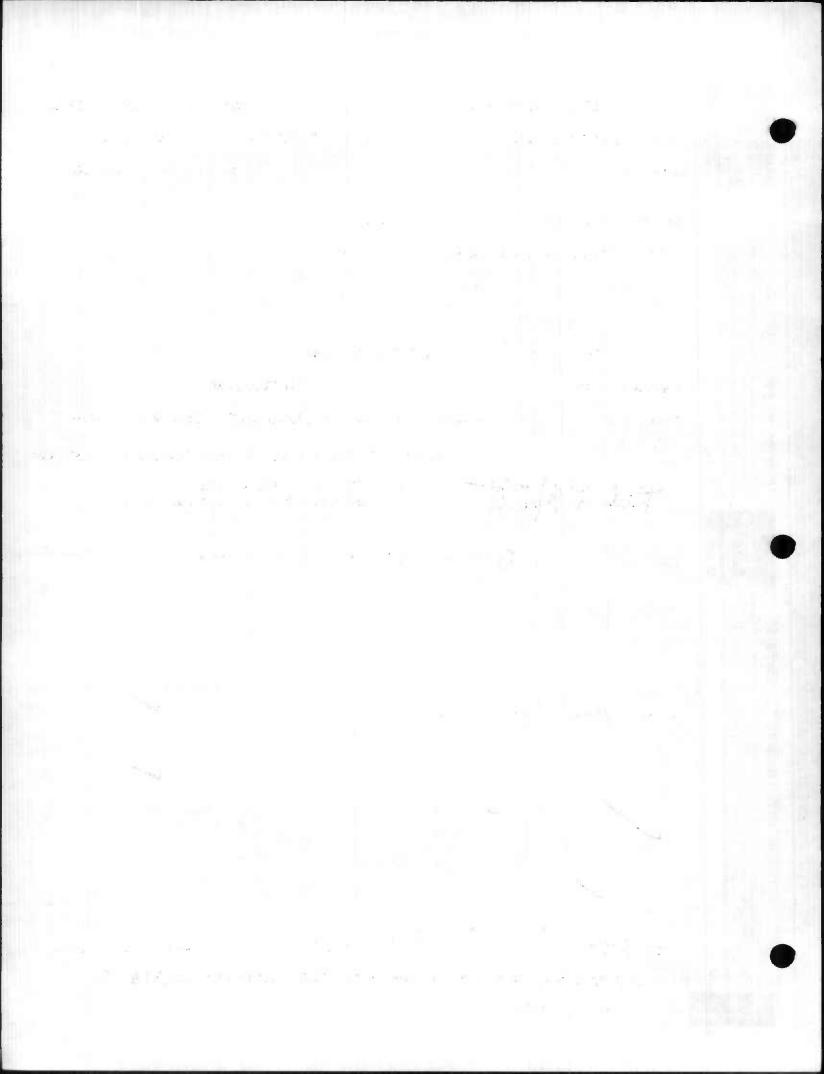


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** ANNA PAULINE KNEPP MIEHL. 22 1998 MAY 0145am /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL ALLEGANY CUMBERLAND If Undar 24 Hrs. If Undar 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) JAN 14 1916 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Months Days Hours MARYLAND 1 M 2 TAF 219-14-5010 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If term 23 is marked other than "natural", or floring 23a or 28a-f show any injury or other traumatic event. In a line of the statement of the 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 √Yes 2 No Directo FLORIDA ST. LUCIE FORT PIERCE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34982 1234 A SOUTH LAKES END DRIVE U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 XWidowed 4 ☐ Divorcad Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work dona during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) 12+ REGISTERED NURSE NURSE 18. Mother's Name (First Middle Meiden Sumame) 17. Father's Name (First, Middle, Last) Be NORMAN PATTON ORPHA MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) DAUGHTER RFD#2 BOX#96 (SHORT GAP) KEYSER W.VA. 26726 JOANN MARKER 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State GRANTSVILLE CEMETERY MAY 24 1998 GRANTSVILLE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
MERRITT-ADAMS FUNERAL HOME 21. Signature of Funeral Sarvige Lice 404 DECATUR STREET CUMBERLAND MARYLAND 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical immediate Cause (Final Terminal 6 marin 5 Bladder disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner end I-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician e Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 98 esn signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 70 3 Probably 4 Unknown The rombosis versons Completed by 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? peen completion of causa of death? has paga 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificata Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 ER/Outpatient 3 DOA After this funeral 27. Manner Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Bratural 5 Pending investigation Injury efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours e 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end manner es steted. Medicai 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) within 2 To the and mannar stated. ŝ AUSERT CHUT 29b. Signature and title of cartifier VILLAMOSA, 29c. Licansa number 29d. Data signed (Month, Day, Year) .0. 052056 MAY 22 1998 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 55 M.D. 925 BISHOP WALSH DRIVE CUMBERLAND, MD. 2150221502 ALBERT VILLAROSA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

MAY 2 6 1998



						$C\epsilon$	ertificate (of Deati	h		Reg. No.) [1107	5		
			Decedent's Name (First, Middle, Last)								2. Deta of Death 3. Tin					
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Vien Vien Henrich	2	Mark Elvin Free Emily V									irginia (Kuhn)					
Sho sho	1	19a. informant's Name/Relati	onship (Type	e, Print)		19b. Mai	ling Address (St	reet and Num	ber or Run	a <i>l Rou</i> te Numi	per, City or Town,	State, Zip.	Code)			
M nd 2		David A. McF	arland	dner	ohew	203	Potomac	Stree	et Cun	nberlan	d MD 215	502				
Star He		20a. Method of Disposition		•		Place of Disp	osition (Name o	d .		Date	20c. Location -	- City or To	own, State			
nt of the or		1 Burial 2 ☐ Crematic		moval from						05/16						
tin tme tant		4 Donation 5 Other			55	nA.	Paul C			05/16	Cumber	Tand	MD			
Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f ahow any Injury or other treumstic event, its Marcial Experience manter resulted as any other treumstic event, its Marcial Experience manter resulted as any once.		21. Signature of Funarai Service Licansee Scarpelli Funeral Home, P.A.														
W 20599		Cumberland, MD 21502														
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Division O To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	Me.	29b. Signatura and title of cert	ifier	P		-	29c. Lic	ense numbe	r		29d. Date signe	d (Month,	Day, Year)			
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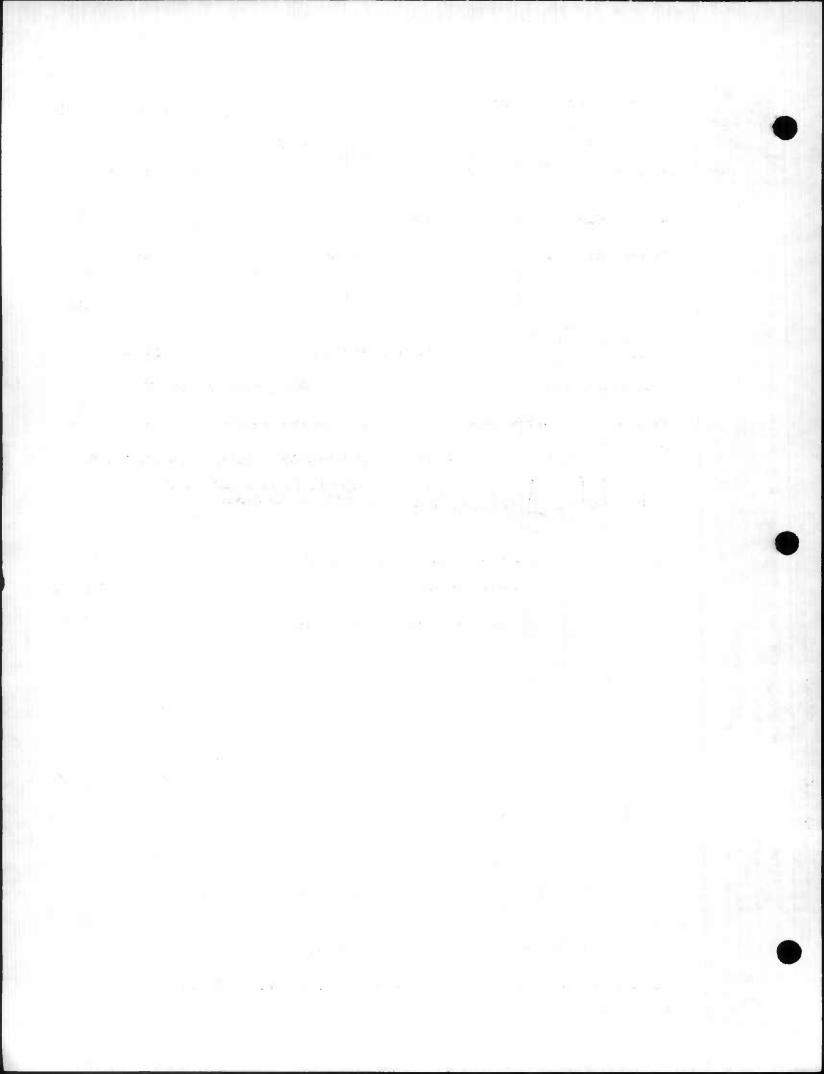
DHMH 16 Rev 6/95

Registrar

MAY 1 91998

218-30-0428

CLARA MANTHEIY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Dete of Deeth Month **Physician** Yeer LINDA NAN NELSON May 14, 1998 11:47 p.m. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Memorial Hospital & Medical Center Allegany Cumberland If Under 24 Hrs. Hours Min. If Under 1 Year 6. Sex Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funerai** 1□ M 20XF Vrs Director 220-52-9701 50 AUG 22 1947 MARYLAND Usual Residence of Decedent the Maryland works 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show 1 ☐ Yes 2 No Directo MARYLAND ALLEGANY LAVALE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10902 THORNWOOD DRIVE N.W. Funeral 21502 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Crigin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after tent of Haalth and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 No Specify: Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced th and Mental Hygiena.
7 is marked other than "natur traumatic event, the Meaner. 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12+ DENTAL HYGIENIST/SECRETARY SECRETARY 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be ALVIN LEO BRILL EILEEN HILDA BARB 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) JOHN L. NELSON HUSBAND 10902 THORNWOOD DRIVE N.W. LAVALE, MARYLAND 21502 or other t 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 Burlal 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Department of important: If any injury or SUNSET CEMETERY MAY 18 1998 CUMBERLAND MARYLAND 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND a. 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medicai Immediete Ceuse (Finel Bronchogenic Carcinoma with Metastases 3 YEARS diseese or condition resulting in death) **Examiner** Due to (or es e consequence of) Examiner The law requires that the death cartificate be executed bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury Ihel initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical the Due to (or es e consequence of): 83 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 3 Probably 4 Unknown signed l Records, þ director, page 2 should 24b. Were eutopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 1 Tyes 2 No this certificate of Vital Hospital or Attanding Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 patient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 20 No Certification: To 28e. Dete of injury (Month, Dey Yeer) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division After Neturel Accident 5 Pending death. 1 Yes 2 No investigetion To the Hospital or Attendent within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) in by 4 Homicide 29a. Certifier ying Physician. To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.

Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) Certifying Physicia Medical (Check onl and menner stated. 29b. Signatur and title of a c. License number 29d. Date signed (Month, Day, Year)

12779

Guy Fiscus, M.D., Memorial Hospital Medical Building, Cumberland, MD

32. Registrer's Signeture

May 15 , 1998

State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

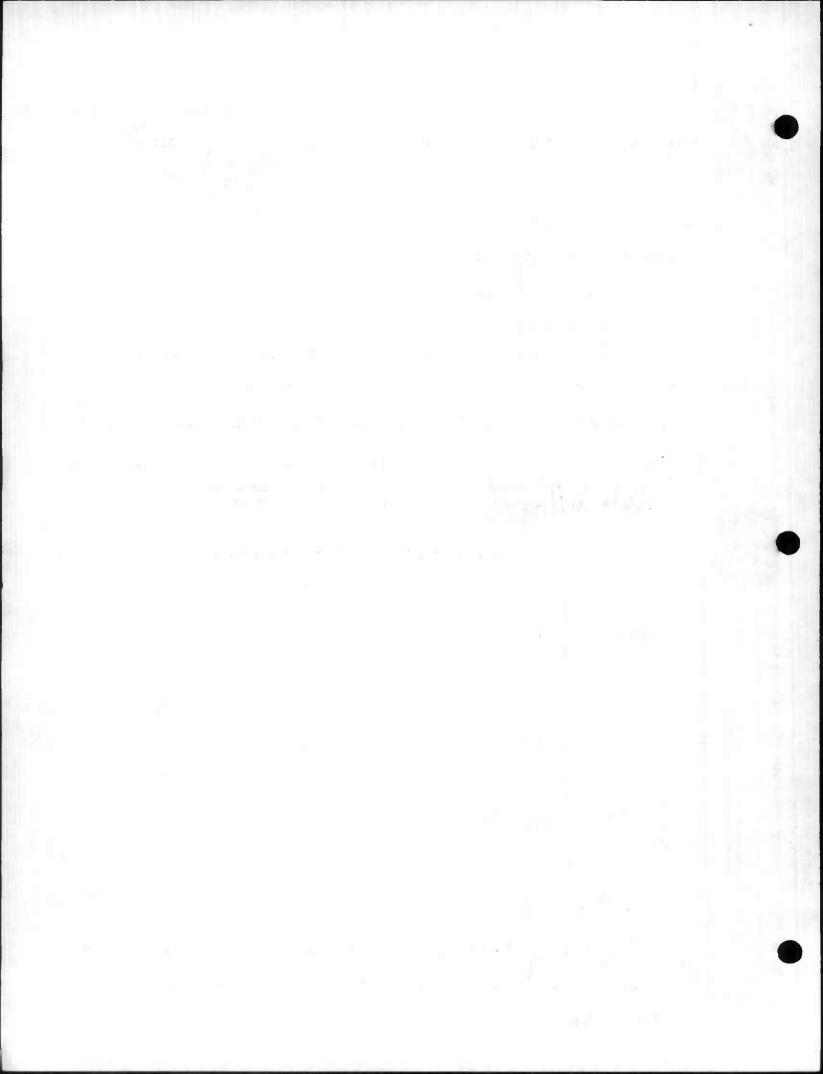
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220-52-9701



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** MAY 17 Day 1998 Year MARY MELISSA NORRIS 1:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CUMBERLAND NURSING HOME CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. APRIL 25 1904 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) 7.7 77 A **Funeral** 1□ M 2√F 94 218-54-1957 Yrs. W. VA. Director Usual Residence of Deceden the Maryland 10a. State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Ves 2 □ No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 135 NORTH MECHANIC STREET death 21502 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status hours after 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: p 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 2 should be filed within 72 h end Mental Hygiena. Is marked other than "natu 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOUSE KEEPER HOUSE KEEPER other traumetic event, permit. Pegas 1 end 2 should be filt Department of Health end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be GABLE FLOYD DAVIS LUCY LARKIN 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 118 STRECKER DRIVE TALLMADGE, OHIO 44278 DENNIS P. NORRIS SON 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ROSE HILL CEMETERY MAY 20 1998 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility MERRITT-ADAMS FUNERAL HOME α . 404 DECATUR STREET CUMBERLAND MARYLAND enter the mode of dying, such as cerdiac or respiratory arrest. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Tha law requires that the death certificeta be axecuted ettending physician and for use as the bunal-transit Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach hydration 3 Probably 4 Unknown 1 Yes 2 No ð pege 2 should 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Completed 24a. Was an autopsy perlomed? peen has 2/XNO certificata 1 Tyes 2 No Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Valursing Home 5 Residence 6 Other (Specify) To 1 Yes 1 Inpatient 2 ER/Outpatlent 3 DOA Certification: 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier cal

Box 68760, P.O. I Records,

Baltimore, Maryland 21215-0020

Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

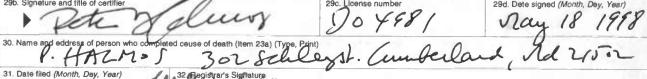
To the Funeral Director: After this certifica completely filled in by the funeral director, 2

> TUS State Registrar

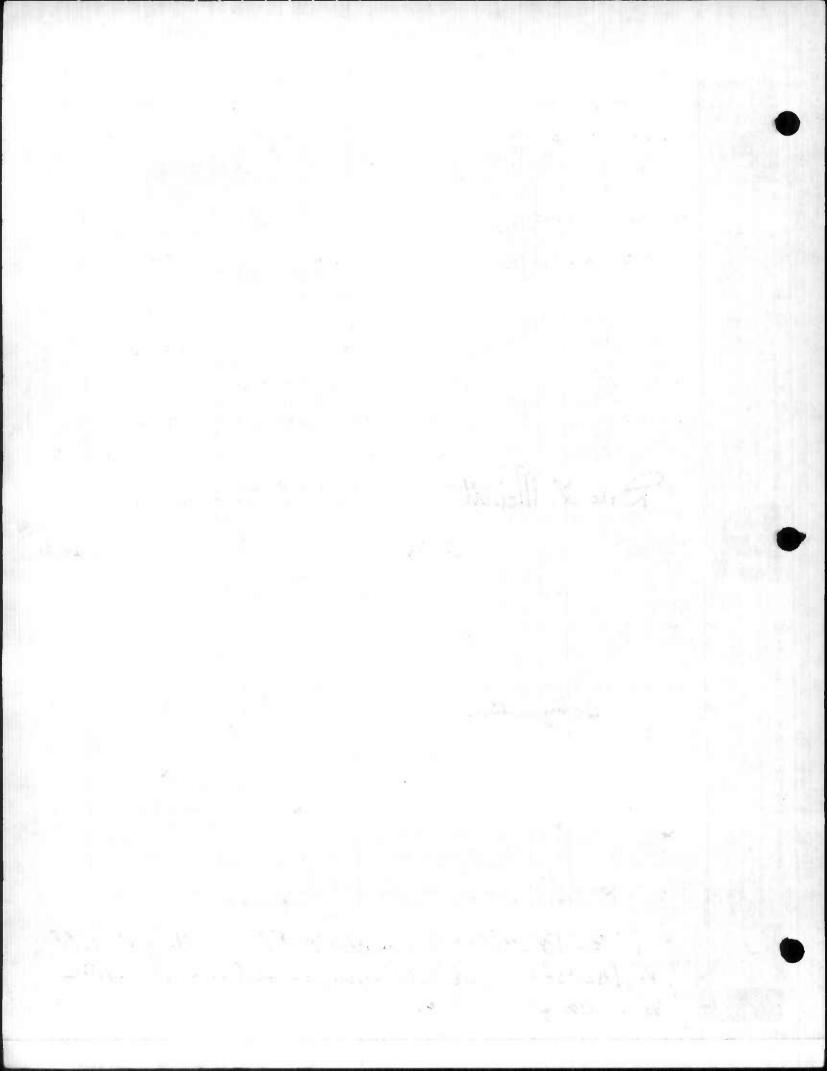
31. Date filed (Month, Dey, Year)

29b. Signeture and title of certifier

(Check only



.32 Registrar's Signature MAY 1 9 1998



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 16, 1998 13:40 PM Joseph Orlick 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Allegany Sacred Heart Hospital Cumberland 8. Dale of Birth (Month, Dey, Year) Jan 31, 1 if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Hungary 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **X**□ M 2□ F Months Days Hours Min 145-07-8166 Yrs. 1903 95 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Frostburg Allegany 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA Frostburg Village Nursing Home 21532 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 整☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes X ☐ No Specify: Specify 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacadant's Education (Specify only highest grede completed) Elamentary/Secondary (0-12) Collage (1-4or 5+) Rutgers University Retired Electrician 12 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Ethyl Gaider Joseph Orlick 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10104 Mockingburd Lane LaVale MD 21502 Charles Orlick-son 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from State Cumberland Crematory Cumberland MD 4 ☐ Donation 5 ☐ Othar (Specify) 05/18 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21. Signalus of Funeral Service Licensee 23a. Part Entar tha diseasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, show, or heart failure. List only one cause on each line. Congestive heart Forthere Due to (or as a consequenca of): Levo Sclerate heart Di Scase Immediate Cause (Final disease or condition resulting in death) 45 Years Atheroscleratie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Peripheral Circulatory and Renal Failure 1 Yes 2 No 1 □ Ves 2 □ No 25. Was case referred to medical examiner? 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospilai: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 | Homicida

that the death certificate be exec Box 68760. P.O. Division of Vital this After t

physician and the burial-transit 950 signed by the a funeral director,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "nature!", or items 23a or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Introcrant: If item 27 is marked other than "natural; or then any Injury or other traumatic avent. In a second of the statement of the state

Physician

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Certification: To

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29a. Cartifiar

(Check only one)

9 1998

/Medical

Baltimore, Maryland 21215-0020

the Maryland

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death

or Attending Physician: after death. Director: Aft Hospital 24 hours a 24 hours a within 2 To the

YUS

State Registrar 1 Certifying Phyalcian: To the best of my knowledga, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year)

, 1998

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) Khander

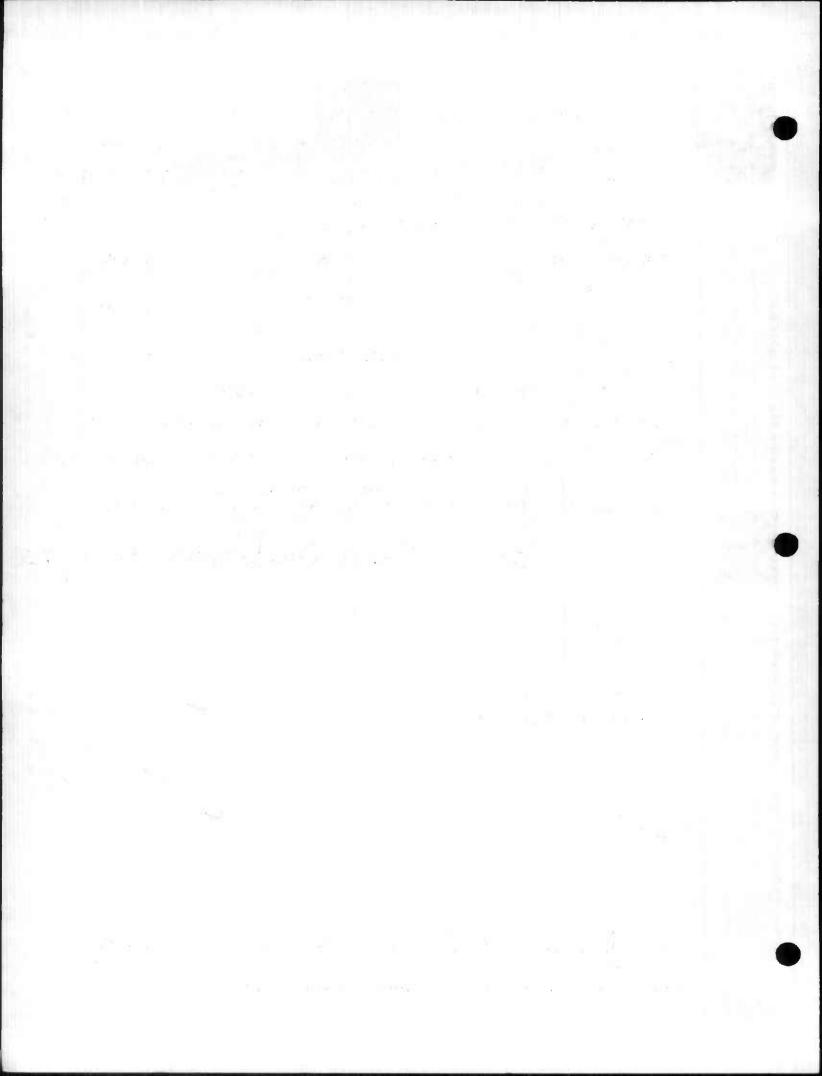
yeausa of daath (Hem 23a) (Type, Print) 48 Tarn Terrace Frostburg MD 2153 a Sanghir 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Exami		4a. Facility Nama (If not institution, give				4b. City, Town, or		4c. County		8:26 AM roline hplaca (Stata or Foraign aryland 10d. Insida City Limits 1 Yas 27 No untry? tes rican Indian, a, atc. ian industry rming 20p Code) 655 Town, Stata aryland yland 21629 Approximata Indiany Batween		
			7788 Shore Drive				Preston			Caro	oline		
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	wor.		10a. Stata 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits		
	Mar a-f st	Director	Maryland Caroli	ne	Presto	n					1 ☐ Yas 2] No		
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	h wil	<u>=</u>	7788 Shore Drive			216	555	1	United	State	25		
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			21. Signature of Funeral Service Licens		-	2. Nama and Add		3/27	Dericon	, riai	Lyland		
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Division	I or Attending after death. Director: Afte d in by the fune	Certification:	3 Suicida 6 Could not be datamined	28a. Place of Inj building, at	ury - At homa, farm, st c. (Specify)	raat, factory, offic	ca		ation (Street and Number or Rural Routa Number, or Town, State)				
	Hospita 4 hours Funeral tely fille	edicai C	29a. Cartifiar (Check only one) Certifying Phy	sician: To the best ner: On the basis of and mannar st	of my knowledga, deat f examination and/or in ated.	h occurred at tha wastigation, in my	tima, data and place y opinion, death occu	, and dua to the c rred at the time, d	ause(s) and ma late and place, a	nner as st and due to	ated. tha causa(s)		
	To the within 2 To the complete	Me	29b. Signature and titla of certifier	0	0	29c. Lica	insa number		9d. Data signad	(Month,	Day, Year		
			Jama	2/	Jer 17	JD.	3/37	6 5	5-21	77	1		
			30. Name and address of person who o	omplated cause of d	leath (Itam 23a) (Type,	Print)	to the second						
			James Sides, M.D.	, PO Box	496, Den	ton, Mar	yland 216	29					

Registrar



Funeral

Director

To Be Completed by Funeral Director

Perry

A.

Fletcher

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			etcher	A. P	erry				Month 1ay	Dey 8	1998	و بلد باد	50a.m	
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5. Social Security Number 6. Sex 7. Age (In yrs. las 213-22-7451) If Unde Months	Days	If Under 24 Hr Hours Mir		Date of Birth Month Day 3 / 0 4 /	,Year) 25	9. Birth Cou Mary	place (Sintry)	tate or Foreign	
Usual Residence	T													
MD MD	Dorch	nester	10c. City, Town or Location ster Hurlock								de City Limits Yes 2 No			
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3 🗗 Widowed	4 Divorced	Yeer or		16a Dece	edent's Usu									
(Spe	cify only highes	st grade completed	(1-4or 5+)	(Give	(Give kind of work done during most of working life. DO NOT use retired)							mpanies		
17. Father's Name	erry			18. Mother's Na			faiden Sume	me)	****	. 5				
4 ☐ Donation 21. Signature of F Mu 23e. Pert1. Enter shock, or he	rit/Da	aughter 3 Gemoval from pecify) Licensee . Chw complications that only one cause on	ceused the dee each line.	6121 Place of Dispersion of Di	E16 consistion (New metory or crest 2. Name a cramp COBO therefore model	ome of other plant Central Address 4 deep of dyind address 4 deep of dyind a d	emetery ess of Facility 1—Hawkin 3, Fede	des 5/ ns- era	dale 212 Eskow 1sbur	Rd., 20c. Location Feder Fune g, ME	Rhocity or T	desdown, Standard Homes 32	, MD	
Immediate Cause disease or condition or condition resulting in deeth) Sequentially list or fary, leading to in cause. Enter Und Cause (Disease or that Initiated event resulting in death)	onditions, mmediate erlying injury		Due to		PC (No equence of)	ion	1. Lure/	LIV	ERF	ALLIR	€	3	days nextles	
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3 ☐ Suicide 4 ☐ Homicide	6 Couid n determi	not be ined 28e. Place build	e of Injury - At ding, etc. (Spec	nome, farm, st	treet, factor	ry, office		28f.	Location (Str. City or Town,		ber or Rur	al Route	Num <i>ber</i> ,	

Medical Certification: To Be Completed by Physician/Medical Examiner (25. Wa exa 1 [27. Mar 1 2 2 3 4 2 29a. Certifier Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) and menner es stated.

2 Madical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/8/98

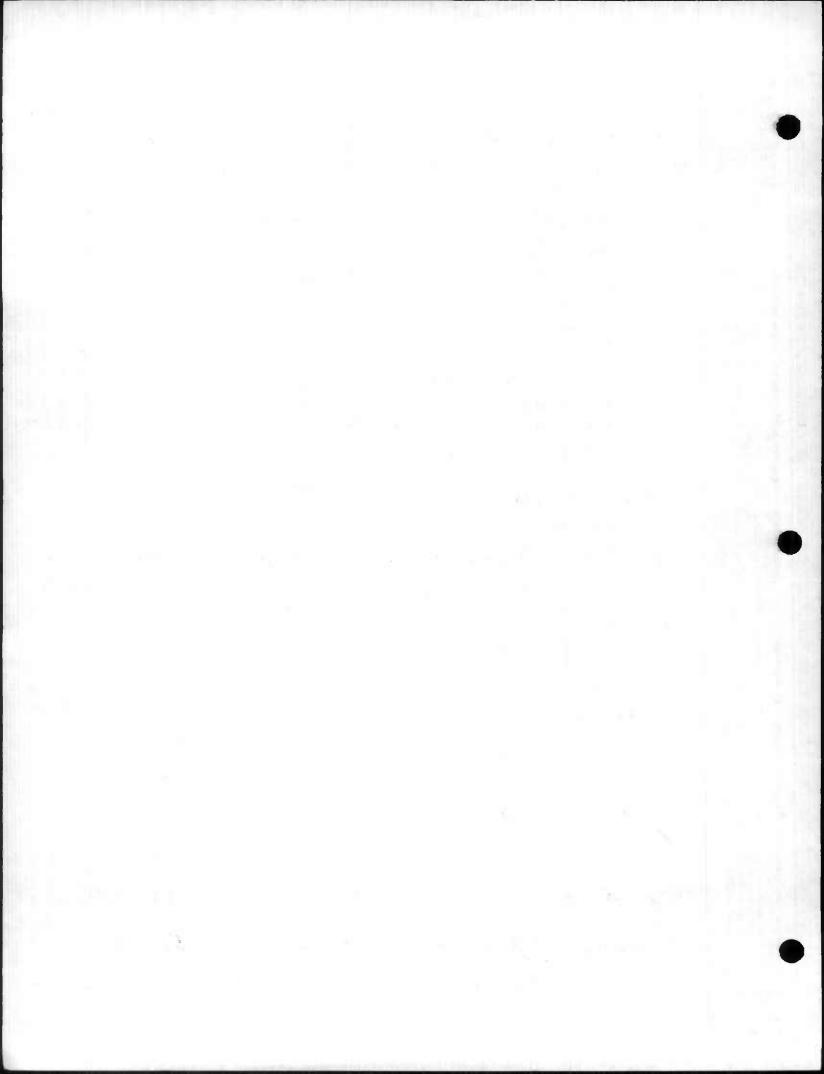
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

J. Fisher, M.D., 511 Idlewild Ave., Easton, MD 21601 Michael

31867

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year PEARL W. PALMAN 16, 11:20 AM MAY 1998 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MEDIPLEX OF GAITHERSBURG MONTGOMERY VILLAGE MONTGOMERY | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, SEPT . 1, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign 1□M 2₩F NEW YORK 79 Yrs. 055-16-4361 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 No MARYLAND MONTGOMERY MONTGOMERY VILLAGE 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? DUFFER WAY 20886 9508 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Raca - Americen Indian Black, White, etc. 11. Marital Status 1 ☐ Navar Married 20 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16e. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Malden Sumame) LOUIS WERNER JULIA GOLDFINGER 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) GLEN PALMAN (SON) 8416 MARKETREE CIRCLE - MONTGOMERY VILLAGE, MD. 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State MT. COMFORT CREMATORY 5/19/98 ALEXANDRIA, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete interval Between Onsat and Death Immediate Cause (Final disease or condition resulting In death) PNEUMONIA 1 WEEK Due to (or as a consequence of) ALZHEIMERS DISEASE YEARS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Wes en autopsy 1 ☐ Yas 2 ♥ No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Death (Check only one) Other: 4₺ Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29c. License number

D45843

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Location (Street end Number or Rural Route Number, City or Town, State)

MAY 17, 1998

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner

Physician

/Medicai

Examiner

10a. State

Funeral

Director

28a-f show

23a death

items 2

natural', or

nd Mental Hygiene. marked other than

traumatic

If item 27 or other true

Peges 1 and 2 should be nent of Health and Mental int: If item 27 is marked or

permit. Pege Department of Important: If any Injury or

Examiner mant be notified at

Director

Funeral

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Completed

Be

the Meryland

filed within 72 hours efter

Examiner the 98

Physician/Medical þ Be Completed

Certification: To

27. Manner of Death

1 Naturai

2 Accident

3 Sulcida

29a, Certifier

4 ☐ Hom/cide

29b. Signature and title of certifier

sician and buriel-trensit The law requires that the deeth certificate be executed Box 68760. physician ettending P.O. I signed bed bed Records. page 2 should Division of Vital Physician: director funeral Hospital or Attending P1
 124 hours efter death.
 Funeral Director: After the testy filled in by the funeral 24 hours Medical Within 2 To the

> State Registrar

30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print) SAMEH ALY - 481 N. FREDERICK AVENUE #230 - GAITHERSBURG, MARYLAND 20877 31. Date tiled (Month, Day, Year)

MAY 1 8 1998

5 Pending

investigation

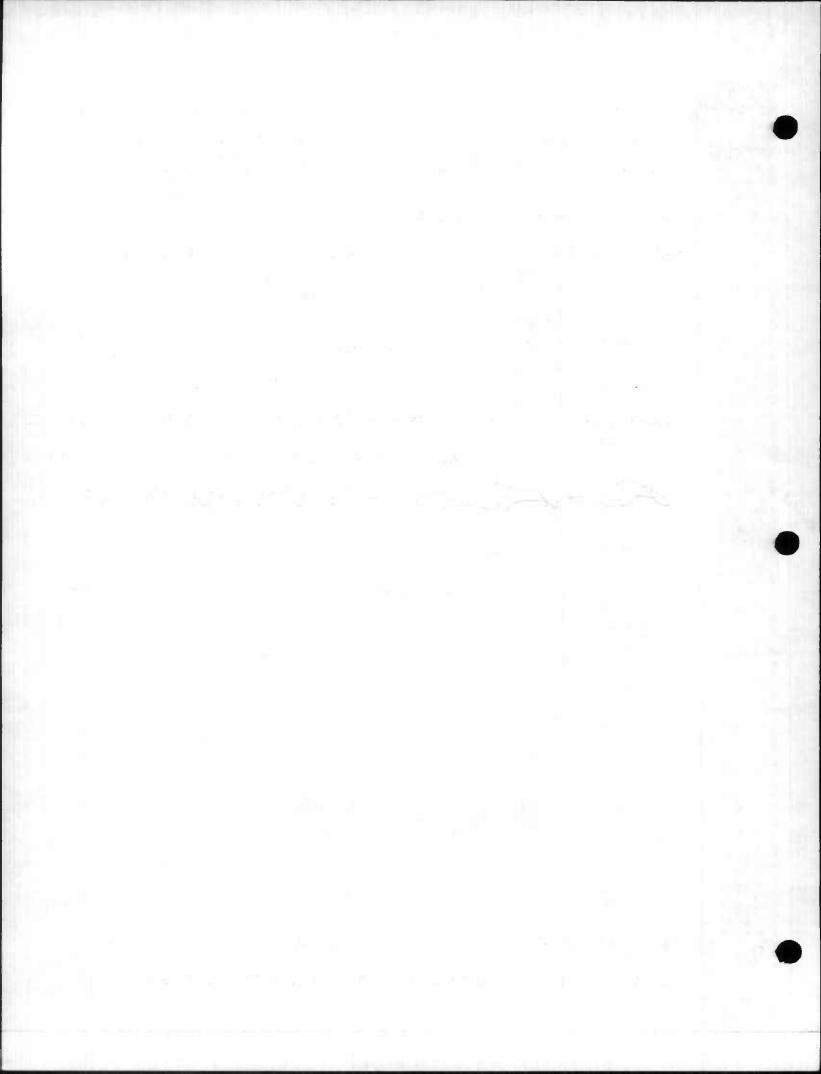
6 Could not be determined

32, Registrar's Signature wie Davidson-Randell

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Date of injury (Month, Day Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:38 AM PARK 1998 May JUN HO 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL clal Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer ROCKVIIIF If Under 24 Hrs. 8. Date of Birth Hours Min (Month, Day, Year) MONTGOMERY 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1**XX**M 2□ F Yrs. KOREA NOV. 29, 1926 220-13-2454 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No SILVER SPRING MARYLAND MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number UNITED STATES 20905 14 JAYSTONE COURT 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritai Status Btack, White, etc. 1 ☐ Yes 2 XXo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXXIo Specify: 3 ☐ Widowed 4 ☐ Divorced KOREAN 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Etementery/Secondary (0-12) FEDERAL GOVERNMENT SUPERVISOR 12 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) CHANG OH KI-YOUNG PARK 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 JAYSTONE COURT, SILVER SPRING, MARYLAND 20905 JENNIFER PARK - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XOBurlat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5-15-98 SILVER SPRING, MARYLAND GATE OF HEAVEN 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HINES-RINALDI FUNERAL HOME, INC. 20904 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death NEUMONIA Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequença of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. othe pulmonon disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? hemengio and other com 2 00 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 2 Accident

Physician /Medical Examiner requires that the death certificate be executed

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

Commit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Hems 23a or 28a-4 show any injury or other traumatic event, the Medical Factorians.

physician and the buriel-transi 98 USB for

Physician/Medicai

Completed by

Be

Certification: To

edical

funeral

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital 24 hours

To the Vithin 2

death. after deatl filled in by

Registrar

completely

CHANALES 31. Date filed (Month, Day, Year)

3 Suicide

29e. Certifier

4 T Homicide

(Check only one)

5 Pending

MAY 1 8 1998

investigation

6 Could not be determined

32. Registrar's Signeture Grota Davidson

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) ISTUS SHADY GROVE RO ROCKULLE MO

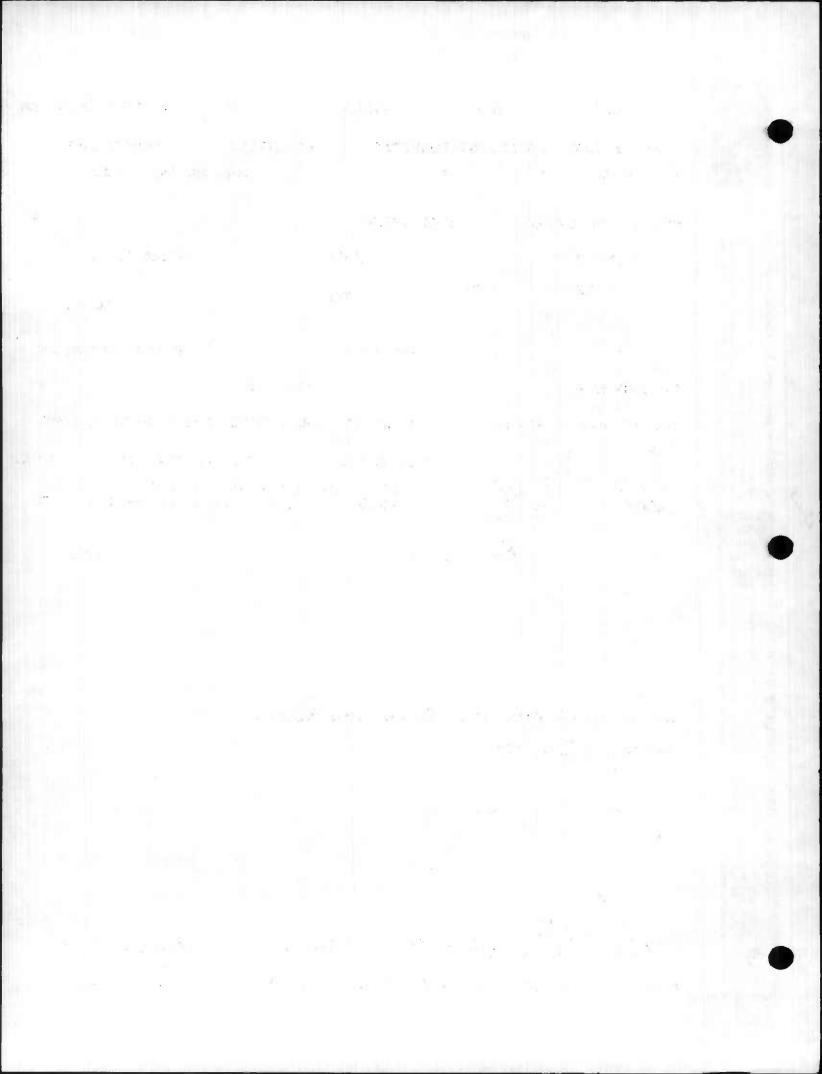
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Dete signed (Month, Dey, Year)

1 TYes 2 No

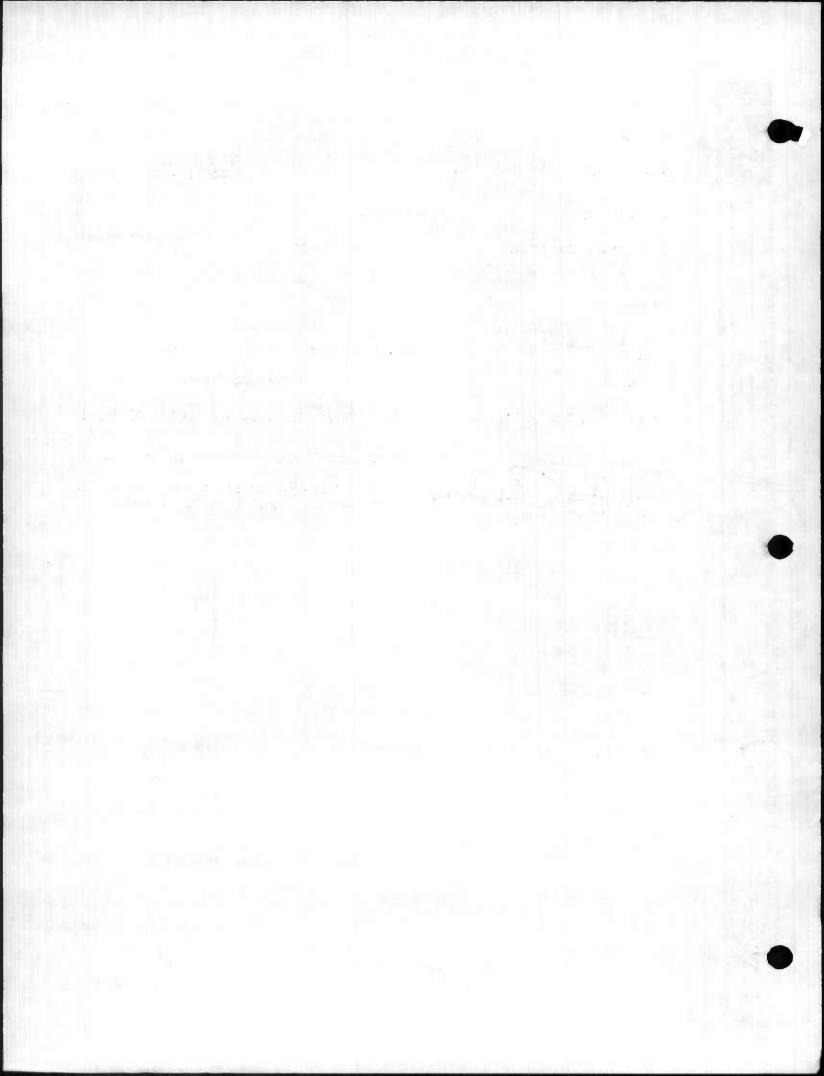
12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 1 16

			Certif	icate of	Death		Reg. No.	1 / 1	10			
Physician /Medical	1. Decedent's Neme (First, Middle, Las Ruth H. Phelps	v)				2. Dete of De Month May 1	Day	Year	ime of Deeth ; 30PM			
Examiner	4a Facility Name (If not institution, give Potomac Valley N				4b. City, Town, or L Rockvill			of Death gomery				
uneral irector	370-00-0173	7. Age (In) M 20 F 97		Under 1 Year onths Deys		8. Date of Bir (Month, De Sept2	th y, _{Year)} 8 1900	9. Birthplece (S Country) Michig	Stete or Foreig an			
28a-f show notified at rector	Usuel Residence of Decedent 10e. State 10b. County District N/A		City, Town or Location						side City Limit			
free must be notified Funeral Director	10e. Street and Number 3109 Beech Stree	t N.W.	1	Of. Zip Code 2	0015		10g. Citizen of V USA	Whet Country?				
by by	11. Maritel Stetus 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Wes Decedent Ever is Armed Forces? 1 ☐ Yes ②E No If Yes, Give Year or Dates:		Decedent of s, specify Cut	Hispenic Origin? (Span, Mexicen, Puerto Specify:	pecify Yes or No Rican, etc.)	Ble	ca - American Ind ck, White, etc. y: White	lian,			
atic event, the Medical I	15. Decedent's Ed (Specify only highest grade) Elementery/Secondery (0-12)	ucetion de completed) College (1-4or 5+)	16a. Decedent (Give kind life. DO) Regist		pation during most of work and)	king	16b. Kind of B	usiness/Industry				
ic event, r	12 17. Fether's Neme (First, Middle, Last) Edwin Hinds	Meiden Sumen										
r trauman	19a. Informent's Name/Reletionship (7 Marriane R. Phel	ype, Print) .ps/Daughter	19b. Mailing A 3109	ddress (Stree Beech	st., N.W.	ral Route Numb , Washi	er, City or Town, ngton D	, State, Zip Code C 20015)			
iry or othe	20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Removel from State	b. Plece of Disposition cemetery, cremetory Mount Ever	ry or other ple		Date 5-20-98		- City or Town, S	tate			
any int	22. Name and Address of Facility Rupert, Durham, Marshall & Gren Funeral Home 5975 Lovers Lane, Portage, MI 49002 23a Paul Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Interval Between Interval Between											
g physician and a set the burial-transit au paying as the burial-transit au paying as the burial-transit au paying a set	Immediate Ceuse (Final disease or condition resulting In deeth) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause, (Disease or Injury	Due \	o (or es a consequen	ce of):	eum oni c	٦			days			
200 =	Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of):											
be detached for usa by Physician/M	Pertil. Other algoriticant conditions of		resulting In the under	lying ceuse g	iven in Pert I.		tobacco use co	ontribute to the o				
ector, page 2 should Be Completed	Seizme a	licorder				perfe	an autopsy ormed?	available completi of death	on of ceuse ?			
To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for usa as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examil	25. Wes cese referred to medicel examiner? 1 ☐ Yes 2 ☑ No	Hospitel:	2 ☐ ER/Outpatient	0	26. Plece of Deather:		one)		2 No			
To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	27. Megner of Deeth 1 Naturel 2 Accident 3 Sulcide 4 Homicide	28e. Dete of Injury (Month, Day Yea	28b. Time of Injury		ork? Yes 2 No	28d. Describe	me 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number,					
To the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifier t⊠ Certifying Phy	building, etc. (Sp	knowledge, deeth oc	curred et the t	ime, date end place	, end due to the	ceuse(s) end m	enner es stated.	ause(s)			
To the f complet	29b. Signeture and title of certifier Grupta, m	end menner steted.		29c. Licen	16398			ed (Month, Dey,				
	30. Name and address of person who co	completed cause of deeth (# 40	99 Rock	cille,	mp	2085				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 14, Robert Keasor Pitman 1998 3:18 PM 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery if Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months 15 M 2□ F Vrs 78 002-01-7846 May 22, 1919 New Hampshire Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zin Code 10g Citizen of What Country? 9500 Bulls Run Parkway 20817 United States 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status Was Dacedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) XYes 2 No f Yes, Give 1 ☐ Never Marriad 2 X Married 1 ☐ Yas 2 € No f Pes, Give Year or Dates: WW II Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry Elementery/Secondary (0-12) College (1-4or 5+) Geologist Dept. of Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Charles Joseph Pitman Mildred Keasor 19e. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9500 Bulls Run Parkway, Bethesda, MD 20817 Mary G. Pitman/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) May 17, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Special) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Funaral Service Licenses M00689 Bethesda, Maryland 20814-3501 Pase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, free. List only one ceuse on eech line. Approximate interval Batw Onset and Death Immadiate Cause (Final disease or condition resulting in deeth) a Sepsis Due to (or es e consequence of): Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that Initiated events rasulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m eny injury or other traum once.

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

10a. State

Funerai

Director

Nem 27 is marked other than "naturel", or Nems 23s or 28s-f show other treumstic event, the Modical Examiner must be notified at

2 should be filed within 72 hours after and Mental Hygiene.

Baltimore, Maryland 21215-0020

the Maryland

death

Examiner

attending physician and for use as the burial-transit signed by t page 2 funerai

Imam, RobeRT

Examiner Completed Be 10

Physician/Medicai Ď

hin 24 hours after death. the Funeral Director: After this 27. Manner of Deeth Certification: 1 Naturat 2 Accident 3 ☐ Suicide 4 Homicide Medicai

29a. Certifier (Check only one)

Renal Failure

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piaca, and due to the cause(s) end manner steted. 29b. Signatura and title of certifian AMMEU

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. Licansa number

D39966

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

May 14, 1998

24b. Were autopsy findings available prior to

completion of cause of death?

1 ☐ Yea 2 ☐ No

24a. Wes an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 lpatient

28a. Date of Injury (Month, Day Year)

Carolyn A. Hammett, M.D. Two Wisconsin Circle, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) MAY 1 8 1998

State Registrar

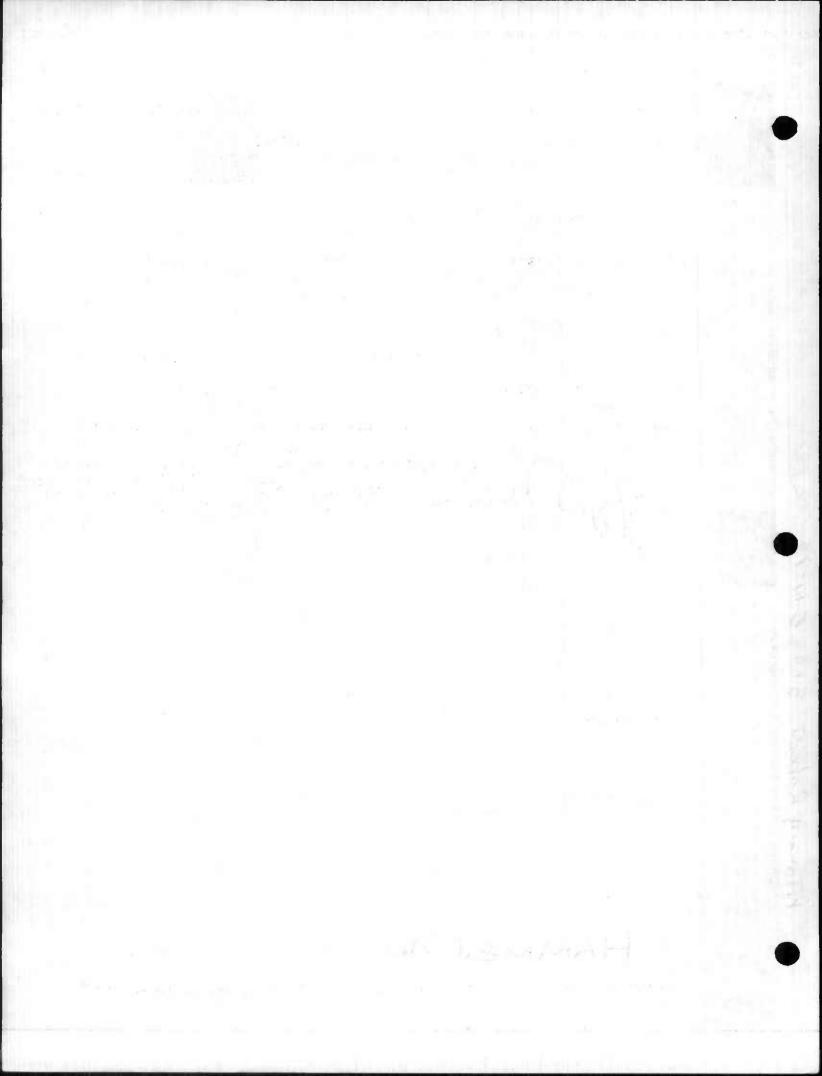
32 Registrar's Signature Irlia Davidson-Randell

DHMH 16 Ray 6/95

within To the

2011

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Deeth 3. Time of Death 1 Decedent's Name (First Middle | ast) **Physician** MAY 17, POSTAL 1998 8:45PM TDA /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner MONTGOMERY GENERAL HOSPITAL MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours 1□ M 2□ F Yrs. JULY 28, 1905 WASHINGTON, DC 92 577-34-0209 Director Usual Residence of Decadent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXXIO Directo NEW JERSEY OCEAN FORKED RIVER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23s or other traumatic event, the Medical Examinal must be not 1444 CLEARVIEW STREET UNITED STATES 08731 Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2XXVo If Yes, Give Year or Dates: 1 Never Married 2 Married 8 1 ☐ Yes 2XXNo Specify: Specify: þ WHITE 3℃Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within end Mental Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) SECRETARY DEPARTMENT OF NAVY 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) TILLIE BELL HYATT WEINBERG 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and 2
Department of Health en.
Important: if item 27 le m
any Injury or other 1444 CLEARVIEW STREET-FORKED RIVER, NEW JERSEY 08731 MURIEL CANDIANO-DAUGHTER 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 1 Buriel 2 □ Cremetion 3 □ Removel from State 5-19-98 FALLS CHURCH, VIRGINIA KING DAVID 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 WCC 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete fntervai Between Onset and Deeth **Physician** Hypo TENSION

Due to (or as e consequence of): Immediete Cause (Final diseese or condition resulting In deeth) /Medical 4-50445 Examiner 4-50445 Examiner ig physician end es the burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Physician/Medical Due to (or es e consequenca of) USB 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yaa 2 No 3 Probably 4 Unknown STROKE þ 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed DEMENTIA 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Certification: 1 Neturel 2 Accident 5 ☐ Pending 1 Yes 2 No r death. Investigation after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide 5 To the Mospital within 24 hours a To the Funeral C filled Hospital edicai 29a. Certifier K Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated. completely 2 Madical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of cartifier MAY, 18th, 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
GAURANG THAKEN MD, 18111 PRINCE PHILLIP Dr 212 DENCYM) 2083 2

State Registrar

MAY 1 9 1998

31. Dete filed (Month, Day, Year)

32, Registrer's Signeture

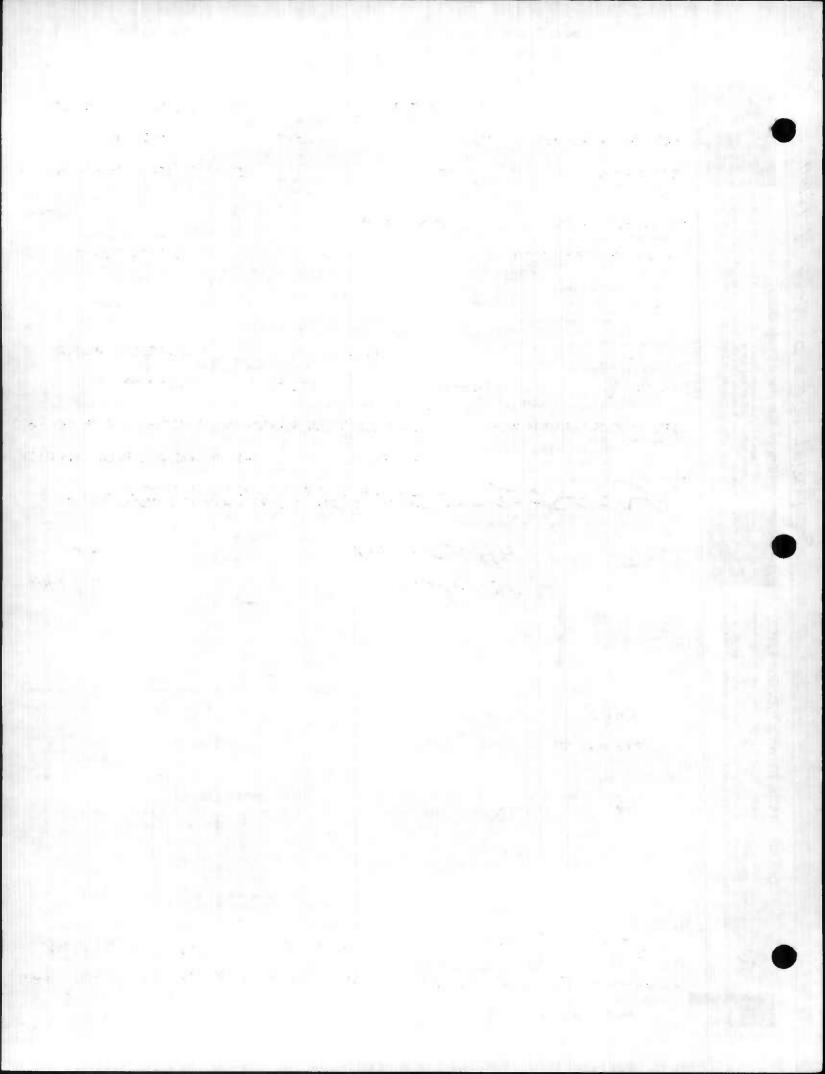
Julia Davidson-Randelle

DHMH 16 Rev 6/95

Postal, 10A

P.O. Box 68760

Division of Vital Records,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Desth Month 05 98 PEARL VIRGINIA 8:30 am PATRICK 4e. Fecility Nama (If not institution, giva streat and number, 4b. City, Town, or Location of Deeth 4c. County of Death Caroline Caroline Nursing Home, Inc. Denton 5. Social Sacurity Number If Undar 1 Yaar if Under 24 Hrs. 6. Sex 7. Aga (In yrs. lest birthdey) Birthpleca (Stata or Foreign Country) 1□M 20 F Months Days Min. Hours Yrs 216-78-3992 88 AUG.7, 1909 WEST VIRGINIA Usuei Residence of Decadent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No TALBOT CORDOVA 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 11760 KITTY'S CORNER ROAD 21625 USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritai Status 14. Rece - American Indian, Black, Whita, etc. 1 ☐ Yes 2 ② No If Yas, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ◯XNo Specify: WHITE 3€Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) -0-HOMEMAKER OWN HOME 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Melden Sumema) AMOS DORSEY HARVEY MARY A. FIKE

Physician /Medical Examiner

permit. Peges 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau

Physician

/Medical

Examiner

10a, Stata

MD

Directo

Funeral

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Completed

Be

Funeral

Director

Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena. Int: If Itam 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0020

item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examinar must be notified at

Examiner Physician/Medicai by Completed director, Be Certification: To

examiner?

27. Menner of Deeth

1. Neturei

2 Accident

3 Suicide

29e, Certifier

4 Homicide

29b. Signature and title of certitian

Wafik Zaki, MD

1 Yes 20 No

5 Pending Investigation

6 Could not be determined

Ob. Piece of Disposition (Neme of cemetery, cremetory or other piece) AIRVIEW CEMETERY		City or Town, State A, MD 21625
22. Nama and Address of Fecility FELLOWS, HELFENBE 200 S. HARRISON S death. Do not enter the mode of dying, such as card		
		Onset and Death
to (or es a consequence of):		
t resulting in tha undarlying cause given in Pert I.	23b. Did tobacco uee col	ntribute to the cause of death?
	24a. Wes an eutopsy performed?	24b. Were eutopsy tindings available prior to completion of causa of death?
	11749 KITTY'S CORNER Ob. Piece of Disposition (Name of cametery, crametory or other piece) AIRVIEW CEMETERY 22. Nama and Address of Fecility FELLOWS, HELFENBE 200 S. HARRISON S death. Do not enter the mode of dying, such as card to (or as a consequenca of): to (or es a consequence of): tresulting in the underlying cause given in Pert I.	AIRVIEW CEMETERY 22. Nama and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNI 200 S. HARRISON ST., EASTON, MD death. Do not enter the mode of dying, such as cardiac or raspirstory arrest, to (or as a consequence of): to (or es a consequence of): to (or es a consequence of): to resulting in the underlying cause given in Pert I. 23b. Did tobacco use consequence?

3□ DOA

28c. Injury at Work?

1 Certifying Phyetcian: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and mennar es stated.
2 Medical Examinar: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and mannar statad.

29c. License number

1 Yes

2 No

21629

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Deta signed (Month, Day, Year)

To the Hospital or Attending Physician: The lew requires that the death certificeta be executed within 24 hours after death. signed by the attending physician end d be detached for use es the burial-transit Division of Vital Records, P.O. Box 68760, peen page 2 s certificate After this funeral within 24 hours after death To the Funeral Director: / completaly filled in by the

> State Registrar

Medicai

30. Neme and address of person who completed cause ot deeth (item 23e) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpetient

28b. Time of

28e. Plece of injury - At home, term, street, fectory, office building, etc. (Specify)

28a. Dete of Injury (Month, Day Year)

PARK I WAR F S

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey 1998 Yeer **Physician** May Russell Ellsworth PHEBLIS 12, 7:25 PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Washington Avalon Manor Nursing Home Hagerstown If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 8. Date of Birth (Month, Day, Yeer)
July 14, 1907
Maryland 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys 489-70-8996 1)X M 2□ F 90 Yrs. Director Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at Maryland Washington Hagerstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14014 Marsh Pike 21742 U.S.A. filed within 72 hours after death Hyglene. Ther than "natural", or items 23 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 9 Never Worked permit. Peges 1 and 2 should be filed Department of Health and Mental Hygli Important: If Item 27 Is marked other eny Injury or other traumatic avent, ib 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Benjamin Ellsworth PHEBUS Clara Gertrude BURGESS 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Miss Margaret E. Phebus, Sister 750 Carroll Parkway, Apt. 6C, Frederick, Md. 21701 20e. Method of Disposition

12 Suriel 2 Cremetion 3 Removal from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete Dete Mount Olivet Cemetery, May 15, 1998 Frederick, Maryland 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22 Name and Address of Facility Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Pert1. Enter the disease, or complications het caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feliure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Sudden Cardens diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner Probable burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Last Due to (or es e consequence of): and P.O. Box 68760, attending physician for use es the buria Probable AZ Physician/Medical Due to (or es e consequence of): Artens relentes Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown suce Records, þ 9 24b. Were autopsy findings eveileble prior to Completed 24e. Wes an autopsy performed? completion of cause of deeth? The law certificate 1 Yes 2 ₩6 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 A Nersing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Hospital or Attending Pl 24 hours efter death.
 Funeral Director: After th Certification: 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral D completely filled 1 Dertifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) end manner stated. 29e. Certifier Medical the th 29b. Slaneture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) May 13, 1998 D (80(7 -CONSTE MS 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Vasant Datta MD 334 Mill Street, Hagerstown, Maryland 21740 31. Dete filed (Month, Dey, Year) MAY 1 5 1998 32. Registrar's Signeture State Registrar

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State of Maryland / Department of Health and Mental Hygiene

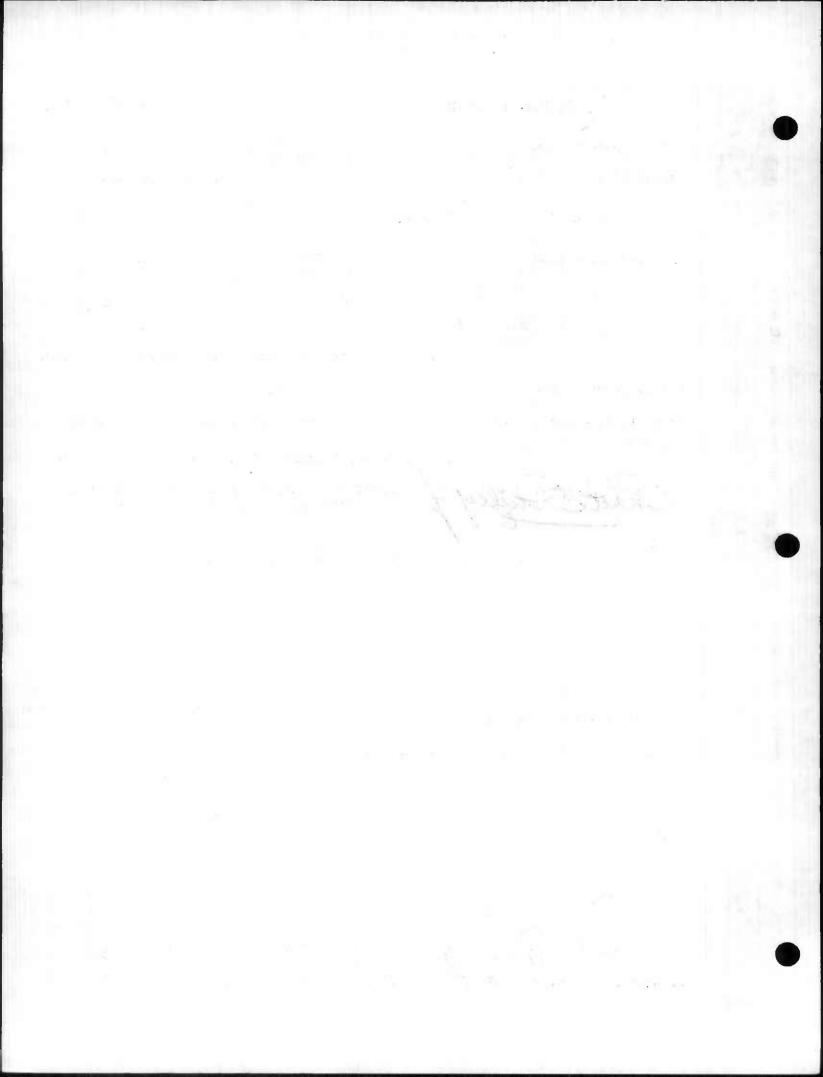
Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Month May 11, Cosby Edna Pigman 1998 4:50 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4h City Town, or Location of Deeth 4c. County of Deeth Examiner 2430 Urbana Pike Frederick Ijamsville If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthpiece (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1 M 2 TF Deys Hours 85 Yrs. 412-30-2159 Director West Virginia March 7,1913 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland nent of Health and Mental Hygiens.
int; if Item 27 is marked other than "natural", or items 23a or 28a-f show int; if Item 27 is marked other than "natural", or items 20a or 28a-f show inty or other traumatic event, in a Medical Enaturies must be notified at 10e. Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Ijamsville Frederick Maryland 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? United States 21754 2430 urbana Pike Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Race - American Indien, Bleck, White, etc. 11. Maritai Stafus 1 ☐ Yes 2 **1** No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No þ 3 MWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Own home Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be 2 Clara Hagerman William Hagerman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2430 Urbana Pike, Ijamsville, Md. 21754 Linda Stevens/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Slele permit. Pages Dapartment of Important: if It any injury or o 1 Burial 2 □ Cremation 3 □ Removel from Stete Jolo, West Virginia 4 ☐ Donetion 5 ☐ Other (Specify) Hatfield Family Cemetery 5/14/98 21. Signeture of Funerei Service Licenses 22. Neme end Address of Fecility Olin L. Molesworth, P.A. Funeral Home 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest,

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Approximate Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Frenchi HUM IN Examiner Due to (or es e consequence of): Examiner requires that the death certificate be executed physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) 60 attanding for usa signed by the a d be datached f Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en autopsy performed? Completed page 2 s cartificata 1 🗆 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funaral director, 25. Wes cese referred to medicel examiner? Be 26. Piece of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 10 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Hesidence 8 □Other (Specify) this Certification: 27. Menner of Deeth 28a. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Naturei 2 Accident 5 Pending aftar death. investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ HomicIde 24 hours a 12 Cartifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner as sfeled.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the fime, date end plece, and due to the ceuse(s) and menner steted. 29a. Certifier Medical To the I 29b. Signeture end fitte of certifier, 29c. License number 29d. Date signed (Month, Day, Year) May 12, 1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Jeffrey N. Cowen, M.D. 310 W.9th Street, Frederick, Md. 21701 31. Dete filed (Month, D 32. Registrer's Signeture State Vin Shudear Randell Registrar

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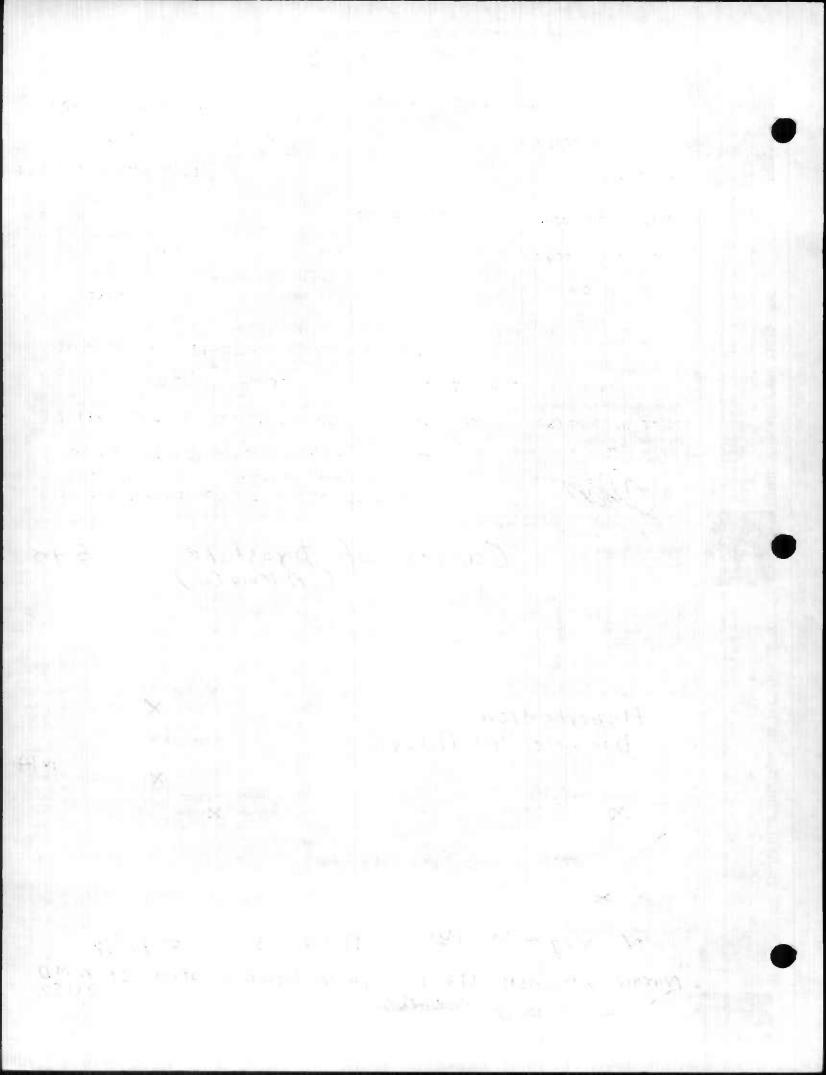


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State of Maryland / Department of Health and Mental Hygiene

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				NAYAN	VAYU	ALA 1	130	Bo	ultimo	re BI	Vd. W	ESTYM	11151	21157			

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

17124

_							Cer	uncai	e or	Deam			Reg. No.		T total 8		
	Physic /Medi		Decedent's Name		Mary C		ne Roh	rer				2. Date of De Month May	Day 13	Year 1998	3. Tima of Death 2:50am		
	Exami	ner		k of Mont	gomery	Villag		w11. J		Ga	ithe	rsburg	M	nty of Death	4		
	Funeral Director		5. Social Security Nur 235-26-83 Usual Residence of D	31	x 7. □M 2\$©F	Age (In yrs. 77	est birthday) Yrs.	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Dec. 2	oy, <i>Year)</i> 8, 1920	9. Birthpi Count West	ace (Stete or Foreign try) Virginia		
	72 hours efter death with the Maryland netural; or items 23s or 28s-f show dical Examiner must be notified at	Director		10b. County Montgo:	mery		, Town or Lo hersbu	ırg	0-4-				10-07		Dd. Inside City Limits		
	with with				77. 1	m 1		10f. Zip					10g. Citizen				
20	s efter death , or items 2:	by Funeral	818 Quince 11. Maritei Status 1 □ Never Marries 3 ☑ Widowed 4	d 2 Married	12. Was Decede Armed Force 1 X Yes 2 if Yes. Give	es? □ No	_			lispanic Ori an, Mexicer		ecify Yes or No Rican, etc.))- 14. F	State	an indian, etc.		
S hour	n 72 hours efte "natural", or i			15. Decedent's Edu	Year or Date	es: WW I	I lea. Deced	ent's Usu	ai Occup	ation				Business/Ind	ite		
0700-01717	iene. than	Completed	(Specify Elementary/Second	y only highest grea	Coitege (1-4	or 5+)	(Give life. L	kind of wo DO NOT u	ork done se retired	during mos d)	t of work	ing		rs off			
and	2 9 D	To Be C	17. Father's Name (F	irst, Middle, Lest)	unl	known					er's Name	e (First, Middle					
			19a. Informant's Nam	ne/Relationship (T)			19b. Maliin	g Address	s (Street	end Numbe	er or Run			vn, Stete, Zip	Code) 20878		
e .	of Heali item 2 other		Mary E. Gookin/ Executor 822 Quince Orchard Blvd, Apt.101 Ga								ithers						
	permit. Peges Department of I important: If ite any injury or o			Other (Specify)		ate	ropoli	tan Name er	Crem	natori ss of Facili	ty				, Virginia		
3	88 2 2 8		Elli	IMO	lesur	Th						P. A. Damascu			20872		
	Physician		23a. Part1, Enter the shock, or heart	disease, or compi failure. List only o	lcations that ceu ne cause on eac	sed the death h line.	. Do not ente	or the mod	le of dyin	ng, such as	cerdiac	or respiretory a	rrest,		Approximate tnterval Between Onset end Death		
6	/Medicai Examiner		Immediate Cause (Fi disease or condition resulting in death)	inal	^	Metas	as a conseq	PE	Rita	suep	11	CANCE			YEARS		
	outed and a sit	Examiner												1			
5	icete be exacuted physician end s the buriel-trensit																
,00000	n certificate be executed anding physician end use es the bunel-trensit	n/Medicai	that initiated events resulting in death) Last Due to (or as a consequence of):														
3		cian	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.														
	requires that the deeth seen signed by the etter hould be deteched for a	by Physicia	Part II. Other significa	ant conditiona cor	ntriouting to deat	n but not resu	iring in the un	derlying o	euse giv	en in Part I			Yee 2 No		the cause of death?		
	2 S	Completed b								-		24a. Was	an autopsy ormed?	ava	re autopsy findings ilable prior to apietion of ceuse eath?		
	The ate t	Con										10	Yes 2 No	1 🗆	Yes 2□ No		
	Physician: The this certificate rel director, peg	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No.		lospitat:			-0.0	Oth			h (Check only					
	a Physer this	n: To	27. Manner of Death	0	28a. Date of I	njury	28b. Time of		28c. Injun Wor	4 JOI NU		me 5 Resi 28d. Describe)		
	Attending r death.	catio	D⊠Naturai 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not be		Day Year)	Injury	М	1 🗆	Yes 2□							
	tal or Attendessis effector:	Certification:	4 ☐ Homicide	determined	28e. Piace of building,	Injury - At ho etc. (Specify	me, farm, stre	et, factor	y, office			28f. Location (City or To	Street and Nui wn, State)	n <i>ber or R</i> urei	Route Number,		
	To the Hospital or Attending I within 24 hours elter death. To the Funerel Director: After completely filled in by the funerel completely filled in by the funerel completely filled in by the funerely	edical	29a. Certifier (Check only one)	Cartifying Phys	elclan: To the be ner: On the basis and manner	s of examinati	vledge, death ion and/or inv	occurred estigation	at the tin , in my o	ne, date an pinion, dea	d piace, th occurr	and due to the red at the time,	cause(s) and date and place	manner as sta e, and due to	ated. the cause(s)		
	vithiu To th comp	¥	296. Signature and ye	le of certifier	Beur		N	290		e number 306	92		29d. Date sign	3, 199			
			30. Name and addres			-	, , , , ,	,									
			Gabriel 31. Date filed (Month,	A. Berret					ad	Suite	305	, Rocky	ville,	Maryla	nd 20850		
	Sta Registr			Y 1 4 199	8	strar's Signat	sor Real	184									

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Reyno Mac 0640 am Bryant /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours Director 218-66-5173 43 Feb. 5, 1955 Washington D.C. Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Damascus 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 20872 10416 Sweepstakes Road United States Funeral 14. Rece - American Indien Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status 1 ☐ Yes 2 🖾 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2X Merried 1 ☐ Yes 2 ☒ No Specify Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Delivery Person Plumbing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) 2 Osker Craig Reynolds Patricia M. Williams 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Elizabeth M. Reynolds/ Wife 10416 Sweepstakes Road, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State any injury or o 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donation 5 □ Other (Specify) 5/16/98 Pleasant Hill Cemetery Monrovia, Maryland 21. Signeture of Funeral Service Licentum 22 Name end Address of Fecility Ølin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Pert1. Enter the disease, or complications that causing the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each in a Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequente de) Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 20 No 2 1 No 25. Was case referred to medical exeminer? Be 28. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 C Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 C Homicide

physician and the buriel-transit certificeta be Division of Vital Records, P.O. certificate has or Attanding Physician: After this after death. Director: Af

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filed within 72 hours efter death

Saltimore, Maryland 21215-0020

ham 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Modical Examinar must be notified at

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permit. Pages 1 and 2 should be filled Department of Haalth and Mental Hygis Important: If Itam 27 is marked other

88 USB 2 funeral Mospital of 24 hours a Funeral D

1 🗠 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner as stated.

29e. Certifier (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end menner stated. 29b. Signaltive end title of cartifier

29c. License number

, Warnescus, Mary land

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause o

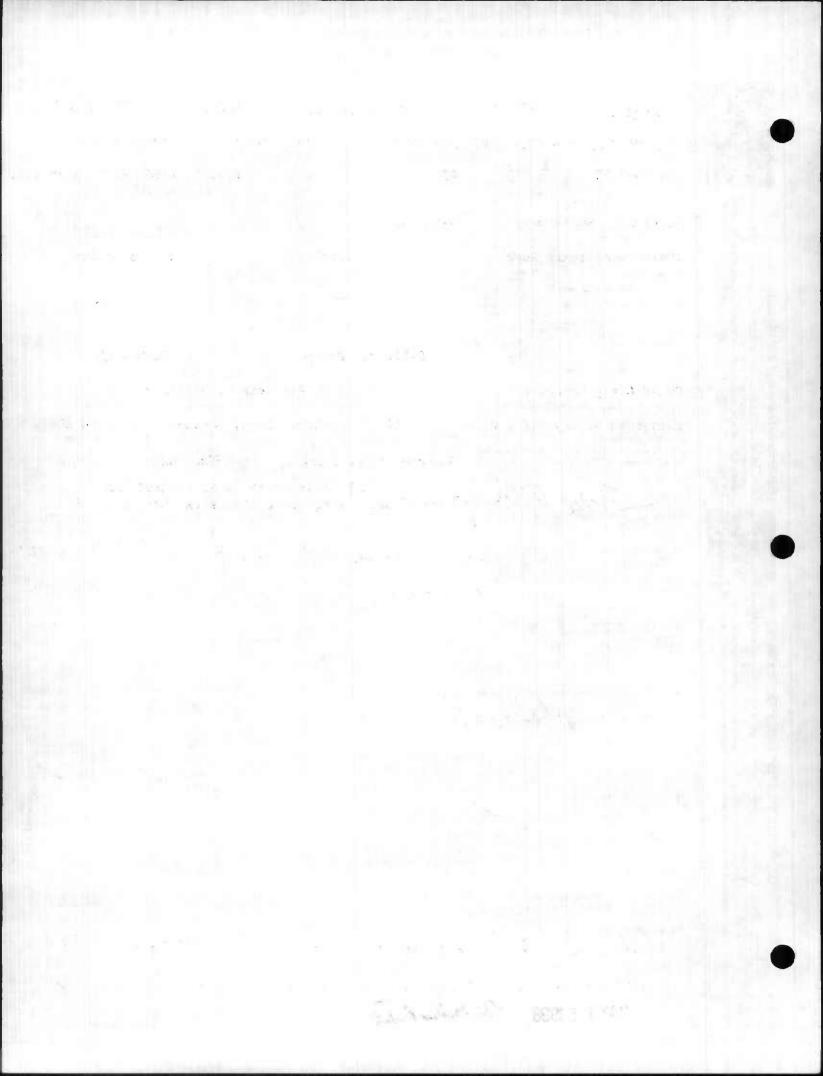
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State Registrar

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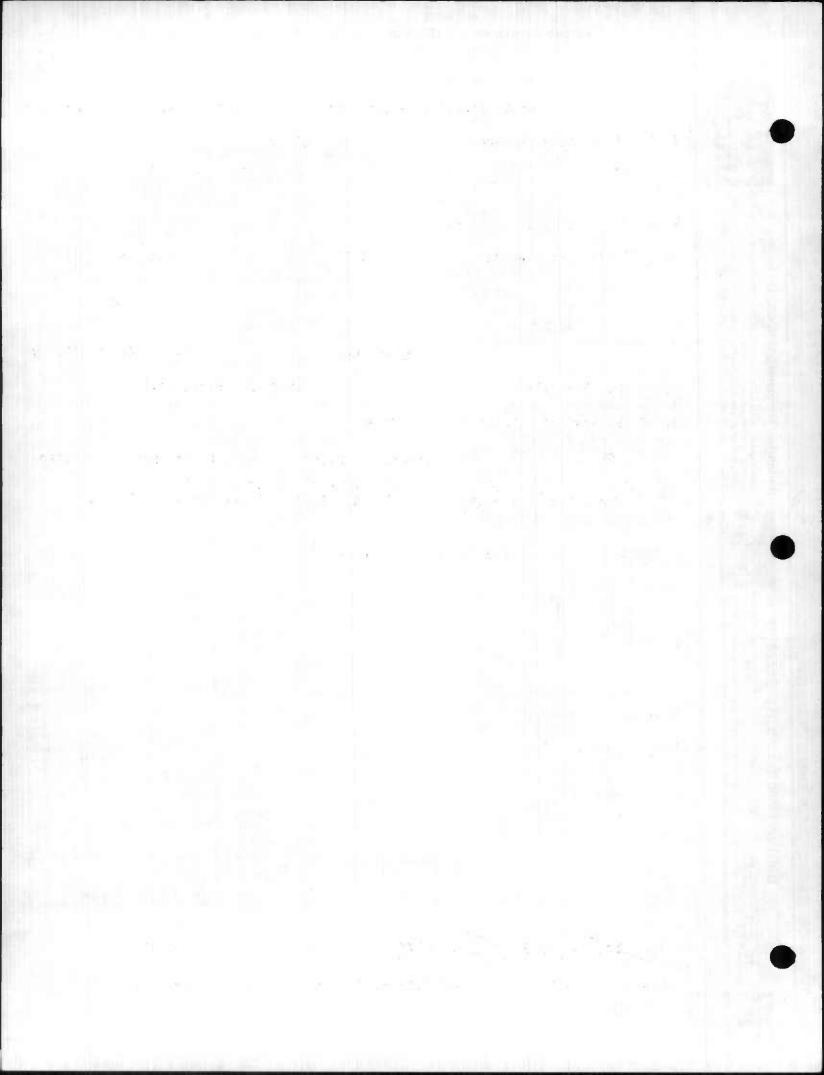


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 15, 1998 Donna Formella Ravenscroft 3:40 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner 2521 Little Vista Terrace 01 ney Montgomery 8. Data of Birth (Month, Day, Year)
NOV. 24, 19 If Under 24 Hrs. If Under 1 Yaar 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2CXF Months Hours 37 1960 232-92-5423 Illinois Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Menyland Department of Health end Mental Hyglene. Important: if them 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Hedical Editions must be notified as 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2521 Little Vista Terrace 20832 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specity: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Senate Library Librarian 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Be John R. Formella Joan Α. Drefcinski 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul F. Ravenscroft (husband) Same as 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-19-98 Beltsville, Maryland Chesapeake Crematory Rapp Funeral Services, P. A. 21. Signature of Funeral Service Licensage 933 Gist Avenue, Silver Spring, MD 20910 Klen the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Entar the disease, or complications that cedsed shock, or heart failure. List only one cause on each lir Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Metastatic Colon Cancer 3+ years disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner physician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 89 usa to signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No Rectovaginal Fistula þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Herpes Zoster Infection s certificate hes b 1 Yes 2 No 1 □ Yes 2 No or Attending Physician: funeral director, 25. Wes case referred to medicel examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 X Natural 1 Yes 2 No A Funeral Director: A Pletely filled in by the f 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Hospital 1 Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier edicai (Check only one) To the F within 2 To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of gertifier D 35996 May 18, 1998 nola MO 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Linda M. Burrell, D., 2101 Medical Park Drive, #210, Silver Spring, MD 20902 31. Date filed (Month, Day, Year)
MAY 1 9 1998 32. Registrar's Signature State Likia Davidson-Randall Registrar

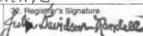
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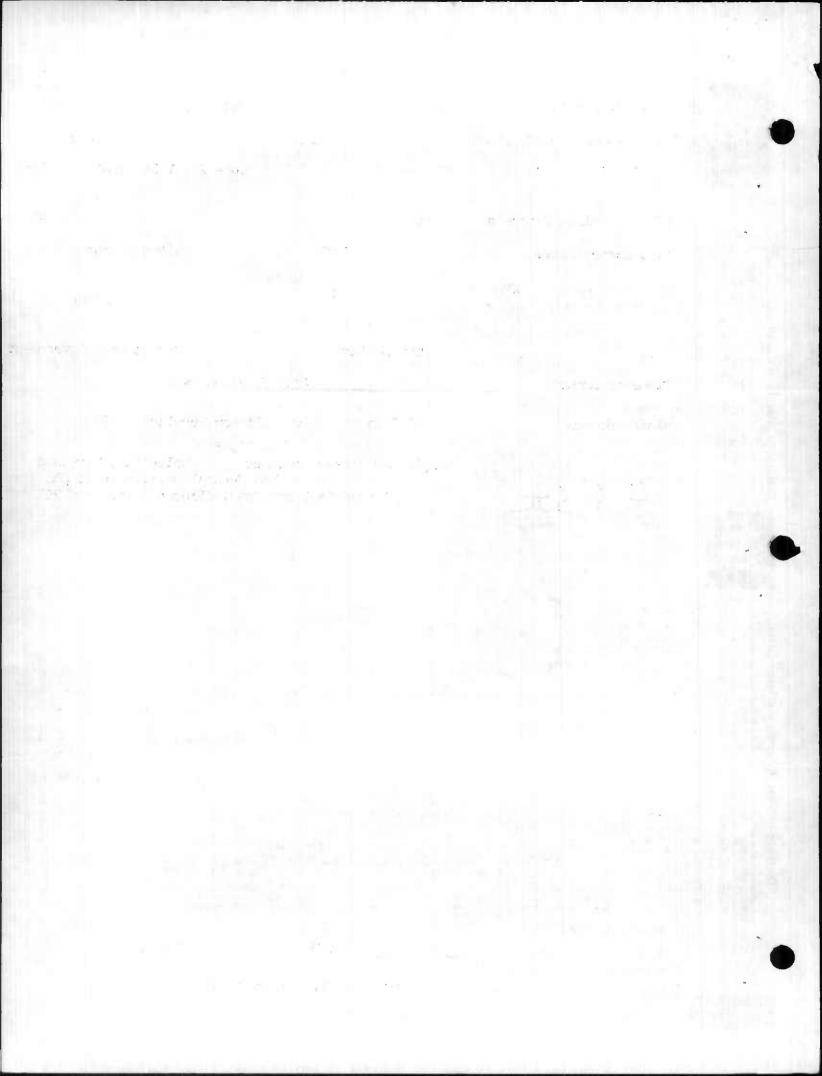


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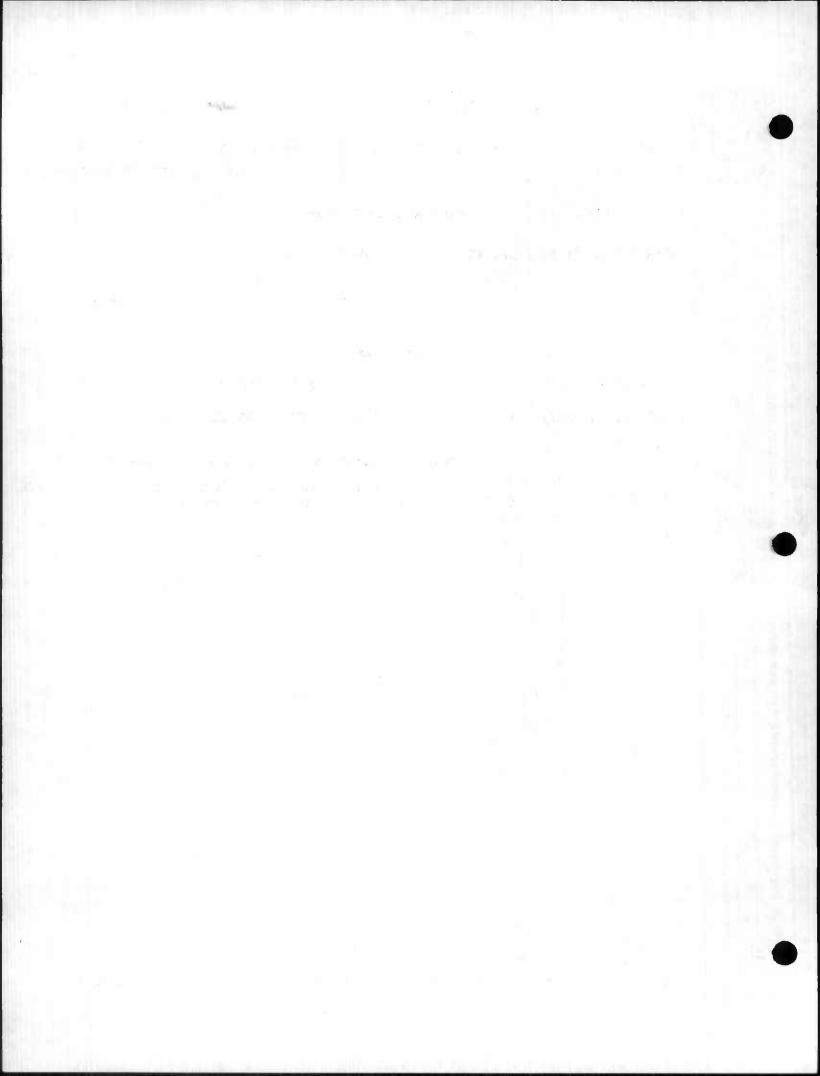
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R	OGERS	Items: 23 part I,27					Health and I Death		giene 9 8	17	127	
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	Funeral Director		Sex 7. Ago 1 ☑ M 2 □ F	63	Yrs. If Unc	der 1 Year s Deys		8. Dele of Bir June 28	th Year 934	9. Birthplace South	(State or Foreign Carolina	
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	ter death with the Marylan tame 23a or 23e-f show the rough or notified at Funeral Director	10e. Street end Number 5828 Barnes Driv		CIIII		Zip Code	35		10g. Citizen of V United	What Country?	**	
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Maryland 21215-0020	within than than		Education rade completed) College (1-4or 5	4)	e. Decedent's U (Give kind of life. DO NOT	work done use retin	ipation a duning most of wor ed)	rking	16b. Kind of Bu		y Governmen	
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	d 2 should be and 7 la material traumaterial	19e. Informent's Neme/Reletionship Elaine Rogers	(Type, Print)				ot and Number or Ru Drive, Cl				/e)	
Baltimore,	8 5 2 0	20e. Method of Disposition 1		ceme	of Disposition (finery, crematory of Land Vet	r other pl	aca) May s Cemeter	18,98 V	20c. Location - Cheltenh			
Balt	pemit. Page Department of Important: If any injury or price.	21. Signature of Funeral Service Lieu	H H		22. Name	end Addi	ress of Fecility ee a Ferry R	Funera.			3 Old nd 20735	
The same of	Physician Medical Examiner	23e. Pert1. Enter the disease, or conshock, or heart failure. List only immediate Ceuse (Finel disease or condition resulting in death)	nplications that caused y one cause on each life ATHEROSCLI	EROTIC C		JLAR D		c or respiretory e	errest,	Inte	proximete ervel Between set end Deeth	
	axecuted n and ial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	b	Due to (or es	e consequenca o	of):			14.2			
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	and w=		Usual Residence of 10a. State	10b. County	10c. C	ity, Town or	Location				10	Od. Inside City Limits
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	r 28a	Director	10e. Street and Nu	umber			10f. Zip Code			log. Citizen of	Whet Coun	try?
	th wit		19310 CL	UBHOUSE RO	DAD APT 417		20879		1	J.S.A.		
altimore, Maryland 21215-0020	n 72 hours after death with the Maryland "natural", or items 23s or 28s-f show ideal Evantiner must be nutified at	by Funeral		rried 2 Marrled	12. Wes Decedent Ever in the Armed Forces? 1 Yes 2 No if Yes, Give Yeer or Dates:	J,S. 13	B. Was Decedent of If Yes, specify Cub		pecify Yes or No- Rican, etc.)		ce - America ck, White, e	etc.
5-0	hin 72 hc in "natur Wed col	eted	(Sne	15. Decedent's Ed	ucetion	16a. Dec	cedent's Usual Occup	pation	kina	16b. Kind of B	usiness/Ind	ustry
121	5 3	Completed	Elementary/Sec	ondary (0-12)	College (1-4or 5+)		ve kind of work done DO NOT use retire	d)	9			
75	TO CO Se		17 Follogo Nomo	(First, Middle, Last)		HOME	MAKER	do Markada Nasa	- (Final) 82 4 4 -	OWN HO		
and	be do do	Be		BOU THOMAS	3			18. Mother's Nam		Meiden Sumen	10)	
Z	d 2 should b th and Ments 7 Is merked traumatic e	2		lame/Reletionship (7		10h Ma	illing Address (Street			r City or Town	State Zin	Code
Ma	d 2 s			. RICKARD,			ASPEN ST					C000)
re,	s 1 and 2 if Health item 27 l		20a. Method of Dis	sposition	20b.	Place of Dis	position (Neme of		Date	20c. Location	City or To	wn, Slate
mo				☐ Cremation 3 🔀 5 ☐ Other (Specify	Hemover from State		emetory or other ple		5/26/98	DIFACAN	MAZTI I	E MI
alti	# 돌림을			meral Service Licens	011	T	22 Name end Addre	ess of Fecility				
m	Depa Impo any ir		MY	inh ym (Peters.						ISCON	SON AVENUE
			23a, Party Enter	the disease or comp	dicetions that coused the dea	th. Do not e	nter the mode of dyi	ng, such es cerdiac	or respiratory are	LO rest,	T	Approximate
	Physician		9		a /						1	Interval Between Onset and Death
и	/Medicai		Immediate Cause disease or condition	(Final on	Rouse	CHOPA.	relail si	Jorc 4	down			11101/205
П	Examiner		resulting in death)		Due to	es a cons	equence of):		1	,		-unorce
	sit ed	Examiner			a. Acuse Due to 1 b. Atherose ke	rcifee	Coroner	y vosco	slan al	ssee as	cili	Month
	ficate be axecuted physician and s the burial-transit	хап	Sequentially iisl co if any, leading to in cause. Enter Und	onditions, mmediate	Due to (or as a cons	equence of):				1	
68760,	sician burie		cause. Enter Und Ceuse (Disease of that initiated event	r injury	C						<u> </u>	
687		edical	resulting in death)	Last	Due to (or as a cons	equence of):					
Вох	ath certif attending for use a	2			d							
	that the death certi ed by the attending detached for use a	Physician/M	Part II. Other algni	ificant conditions or	ntributing to death but not re	sulting in the	underlying ceuse git	ven in Part I.	23b. Did to	obacco use co	ntribute to	the cause of death?
P.0	the ach	hys							1 🗆 Y			ably 4 Unknown
	5 5 6	by F	05	yeo or th	11715							
of Vital Records,	een s	Completed	14	andre la	1. Vis 1 Lu Jene 400	n -	luca H	790	24a. Wes e		ava	re autopsy findings illable prior to inpletion of cause
Sec	aw ls b	npie	Y	200000	, , 0 - 0, 0		1-1000/10	1				leath?
E F	Page ate								1□ Y	es 2 No	1 🗆	Yes 2 No
Vit	ysician: This certificate director, pag	Be	25. Wes cese refe examiner?	-	Hospital:		OH	26. Plece of Dear	th (Check only or	10)		
of	5 00	. To	1 ☐ Yes 2 ☐ 27. Manner of Dea	INO	1 ☐ Inpatient 2 ☐	ER/Outpati	ent 3LI DOA	4 □ Nursing H	ome 5 Resid)
on	ding F. After funer	Certification:	1.20 Natural	5 Pending investigetion	(Month, Dey Year)	Injury	Wo	rk? IYes 2□No	Edd. Describe II	ow injury occur	160	
Division	or Attending aftar death. Director: Afte I in by tha fune	fica	3 Sulcide	6 Could not be	28e. Piece of Injury - At I	iome, ferm,			28f. Location (S		er or Rura	Route Number,
ă	s aftar I Direct	ent	4 Homicide	001011111100	building, etc. (Spec	ty)			City or Tow	n, Stete)		
	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completaly filled in by tha funeral		29a. Certifier (Check only	Certifying Phy	sician: To the best of my kn	owledge, de	eth occurred at the ti	me, date and place,	and due to the d	ause(s) and ma	anner as st	ated.
	the H in 24 the Fi	ledicai	one)	∠ ⊔ Medicat Exam	Iner: On the besis of examinend manner stated.	ation and/or	investigation, in my o	opinion, death occur	red at the time, o	ate and place,	and due to	tne ceuse(s)
	To the within To the comple	Σ	29b. Signature and	title of certifier	/		29c. Licens		2	29d. Dete signe		
	5		1	Mel	u		04	4340		Hon	17,	1988
			30. Name and and		ompleted cause of death (Ite				TIE - DOC-	/		
			Huge la	Fuleon		-	MEDICAL C	ENTEK DRI	VE, ROCK	WILLE,	MD 20	J850
	Sta Registr		31. Date filed (Mor		32. Registrar's Sign	ature	00					
	Hegisti	ar	WIA	Y 2 0 1998	GENEL Davidson	~- Mande	ماتال					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** 15, 2:30 A 1998 GLADYS C. RUSSELL MAY /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Damascus
If Under 24 Hrs.
Hours Min.

May 26, 1928 26040 Woodfield Road, # 10 MONTGOMERY If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 6. Sax **Funeral** 1 M 2 XF Months Days 69 Yrs. Maryland 469-84-6233 Director Usual Rasidance of Dacedant with the Meryland r 28a-f show 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Montgomery 1 X Yas 2 □ No Damascus Director 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hyglane. Important: if itsm 27 is marked other than "naturel", or items 23a or i eny injury or other traumatic avent, the Medical Examples must be in once. 15640 Woodfield Road 20872 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: P 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamentary/Secondary (0-12) Collaga (1-4or 5+) 8th Domestic Home 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Father's Name (First, Middle, Last) Elgia Butler Cora Powell 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20874 19a. Informant's Name/Ralationship (Type, Print) Gertrude Butler (Sister) 19218 Warrior Brook Dr., Germantown, MD 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition N☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 □ Donation 5 □ Other (Specify) Brooke Grove Cemetery 5/21/98 Gaithersburg, MD 21. Signature of unegal Service Licensee Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Enter the dispess, or complications that caused the death. Do not anter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failing. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Immediata Causa (Finat disaasa or condition rasulting in daath) /Medical RE3PIRATORY FAILURS Examiner Examiner CHRONIC OBSTRUCTIVE PULMONARY DISTASE attending physician end for use es the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasuiting in daath) Last Dua to (or as a consequence of): CONGOSTIVO HOMA Physician/Medical Dua to (or as a consequence of): MOZLITUES. AB 5783 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CIRPHOSIS Division of Vital Records, þ 24b. Wara autopsy findings avallable prior to complation of cause of death? CHRONIC PANCRATITIS 24a. Was an autopsy performed? Completed peed certificate has b director, page 2 s PONAL INSUFFICIENCY 1 Yas 2 No 1 Yas 2 No or Attending Physician: director. 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d, Dascribe how Injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 DWatural 1 ☐ Yas 2 ☐ No death. 2 Accidant Director: J 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify) efter 4 ☐ Homicida Euners efter
 Funers! Dire
letely filled in b 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi

State

Registrar

3

Box 68760.

9890 31. Data filed (Month, Day, Year)

29b. Signatura and titla of certifian

(Check only one)

DAMASCUS MARYLAND ROOT 51 32 Registrar's Signature Julia Davidson-Randell

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

9 1998

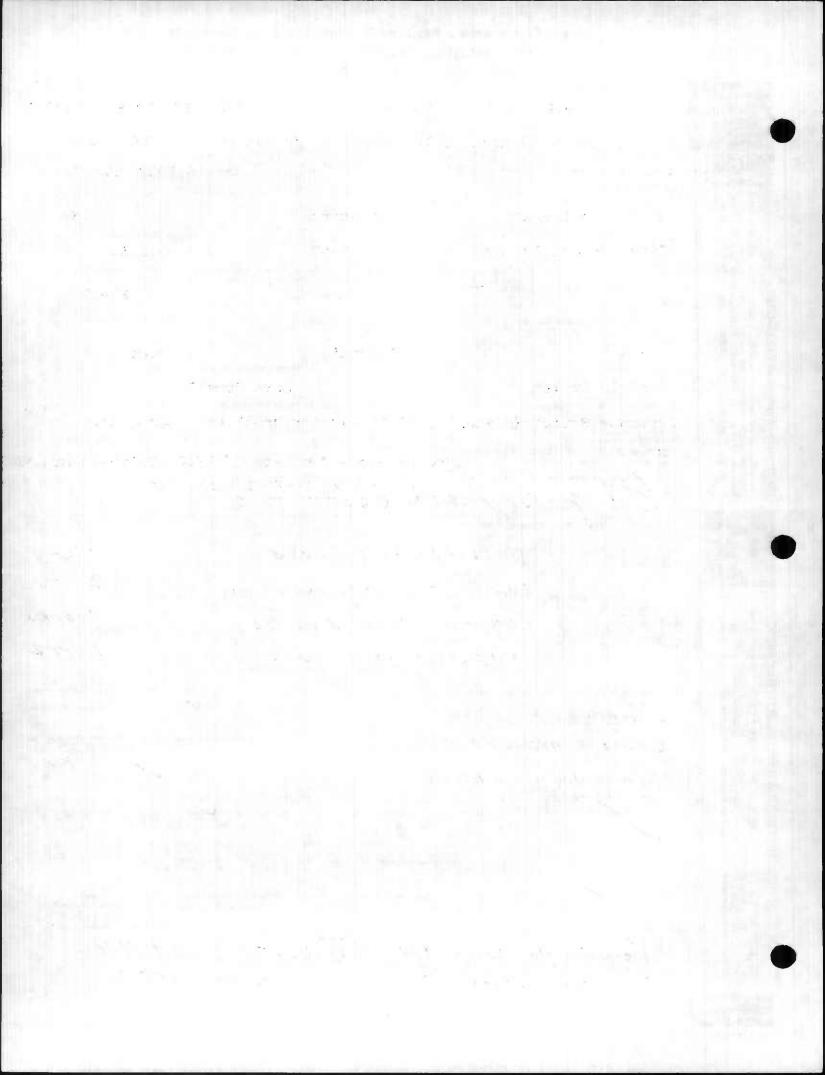
2 Medical Examitner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licansa number
MARYLAND

D/409-

29d. Data signed (Month, Day, Year)

2087



Pleas	e Type or Pri	nt in Blac	k Ind	elible Ir	nk. Ass	ure A	II Copies	Are Leg	jible.	ille
	State of M	aryland / [rtment o			fental Hy	giene Reg. No.	98	17130
1. Decedent's Name (First, Middle, I	Last)						2. Date of De	eath	.100	3. Time of Death
John	Byard Sha	arp					Month May	17.	1998	7:30 AM
a. Facility Name (If not institution, g					4b. City,	Town, or L	ocation of Deat		ty of Death	
The Memoria	al Hospit	al				East	on		Tal	bot
	. Sex 7. Ag	e (In yrs. last bir.		If Under 1 Ye	ear If Und	er 24 Hrs.		rth Vocal	9. Birth	place (State or Foreign
219-03-0813	1 X M 2□ F	81	Yrs.	IVIORITIS De	ays Hours	iviiri.	October	3, 1916	Ma	ryland
Usual Residence of Decedent		10. 01. 7.								
10a. State 10b. County		10c. City, Town	n or Loca	ition						10d. Inside City Limits
Maryland Carol	ine	Dento	on							1□Yes 2√2No
10e. Street and Number				10f. Zip Coo	de			10g. Citizen o	f What Cou	intry?
26124 Hobbs Road	įį			2162	9			Unite	d Sta	ites
11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent Yes, specify C	of Hispanic (Origin? (Sp	ecify Yes or No Rican, etc.)		ace - Ameri ack, White	ican Indian,
1 Never Married 2 Married				☐Yes 251			· · · · · · · · · · · · · · · · · · ·	Spec		, 610.
3 X Widowed 4 ☐ Divorced	Year or Dates:			- 37		,. 		Ca	űcasi	an
15. Decedent's (Specify only highest of	Educetion prede completed)	16a.	(Give ki	nt's Usuai Oc	one during m	ost of work	ing	16b. Kind of	Business/ir	ndustry
Elementary/Secondary (0-12)	College (1-4or	5+)	life. DC	O NOT use re	tired)					
8			Carpe	enter					truct	ion
17. Father's Name (First, Middle, La								, Maiden Suma	ame)	
	Syard Shar						avis			
19a. tnformant's Name/Relationship	(Type, Print)							er, City or Tow	n, State, Zi	ip Code)
Deborah Medford	Daught					lsbur	g, Mar		21632	
20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	20b. Place of cemeter		tion (Neme of tory or other		į	Date	20c. Location	n - City or T	own, State
4 □ Donation 5 □ Other (Spec		Conco	ord (Cemete:	ry	5	/20/98	near I	enton	, Maryland
21. Signature of Funeral Service Lic	egsee / / h			Name and Ad			D 7			
1 Krucos	4 19 01	ane	/	ore Fu				enton	Marul	and 21629
23a. Part1. Enter the disease for co shock, or heart failure. List on	mplications that caused	the death. Do r	not enter	the mode of	dying, such	as cardiac	or respiratory a	rrest,	riar y 1	Approximate
Shock, of field failule. Valst on	y one cause on each in	10.	17	2	/	-			1	Interval Between Onset and Death
Immediate Cause (Final disease or condition	Mi	li e use	n L	has 1	no oli	mar.				Zyn
resulting in death)	a. 104	ligua Dueno (or as a c	conseque	annet ett.	1	rrun				1
		J. C.	and the square	0.,					1	
Sequentially list conditions,	b	Due to (or as a c	conseque	ance of):						
if any, leading to immediate ceuse. Enter Underlying		200 10 (01 40 4 0	oonooque	nico orj.					-	
Cause (Disease or Injury that initiated events	C	Due to (or as a c	conseque	nce of):					-	
resulting in death) Last		Dao 10 (01 as a 0	Jonadae	1100 017.						
	d									
Part II. Other algnificant conditiona	contributan to dooth h	ut not requiting is	a the und	orbina novec	shan in Da	4.1	and Did	tahaana		to the series of death 0
Collin III	contributing to death bi	at not resulting in	i the und	enying ceuse	given in Par	τι.		./		to the cause of death?
Cellulity	leg						10	Yes 2 No	3 Pro	obably 4 Unknown
	()						24a Was	an autopsy	24b. W	/ere autopsy findings
	U							omed?	av Cr	vallable prior to ompletion of ceuse
									of	death?
							10	Yes 2☐No	1	☐Yes 2☐No
25. Was cese referred to medicat examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Ou	itpatient	3□ DOA	Other:		n <i>(Check only one</i> 5 □ Resi	one) dence 6 □0	ther (Speci	ifu)

Physician /Medical Examiner

Physician /Medical

Examiner

Director

Be Completed by Funeral

10

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be inclined as

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriar-transit After this certificate has been signed by the ettending physician and funeral director, page 2 should be deteched for use es the burial-transit Be Completed by Medical Certification: To

Division of Vital Records, P.O. Box 68760,

art li.	Other algnificant	conditiona	contributing	to death	but not r	esuiting in t	ne underlying	ceuse given in P	art

28a. Date of Injury (Month, Day Yeer)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 Yes 2 No

Location (Street and Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

M.D., 506 Idlewild Avenue, Easton, Maryland 21601 William H. Wood, Jr., 31. Date filed (Month, Day, Year)

State Registrar

MAY 19

5 Pending investigation

6 ☐ Could not be determined

27. Manger of Death

1 Matural

2 Accident

4 🗌 Homicide

3 Suicide

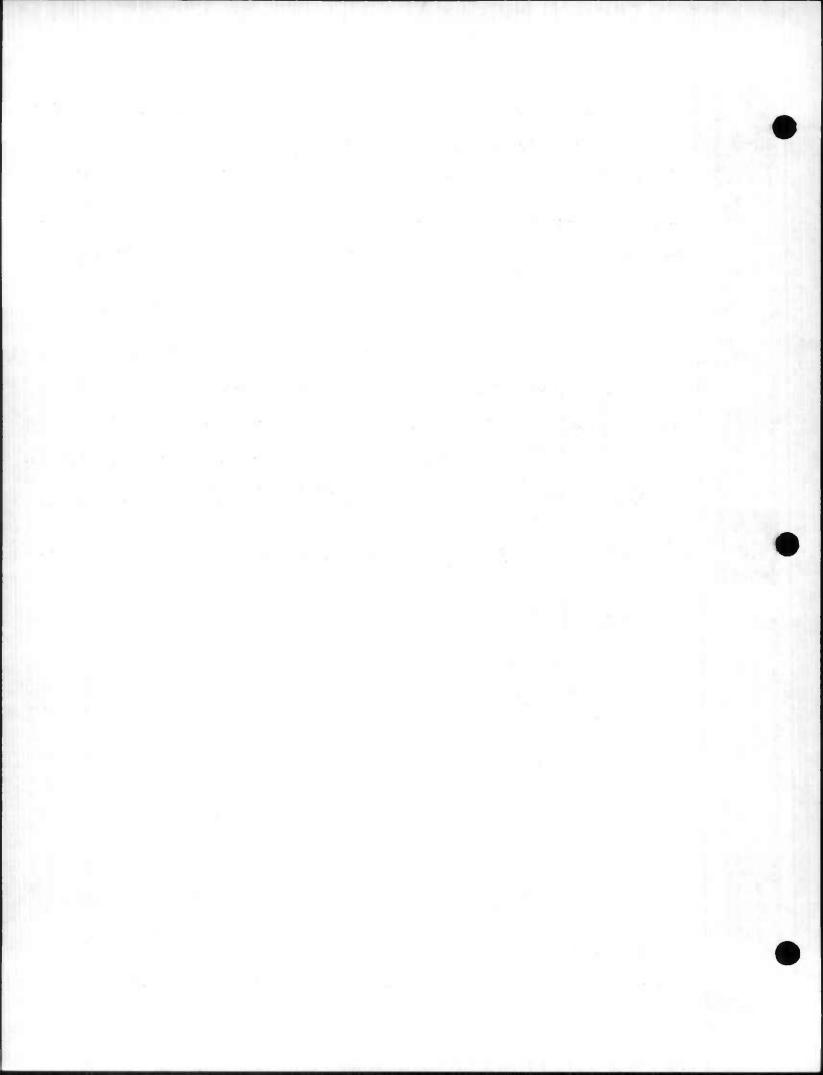
29a. Certifier



Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

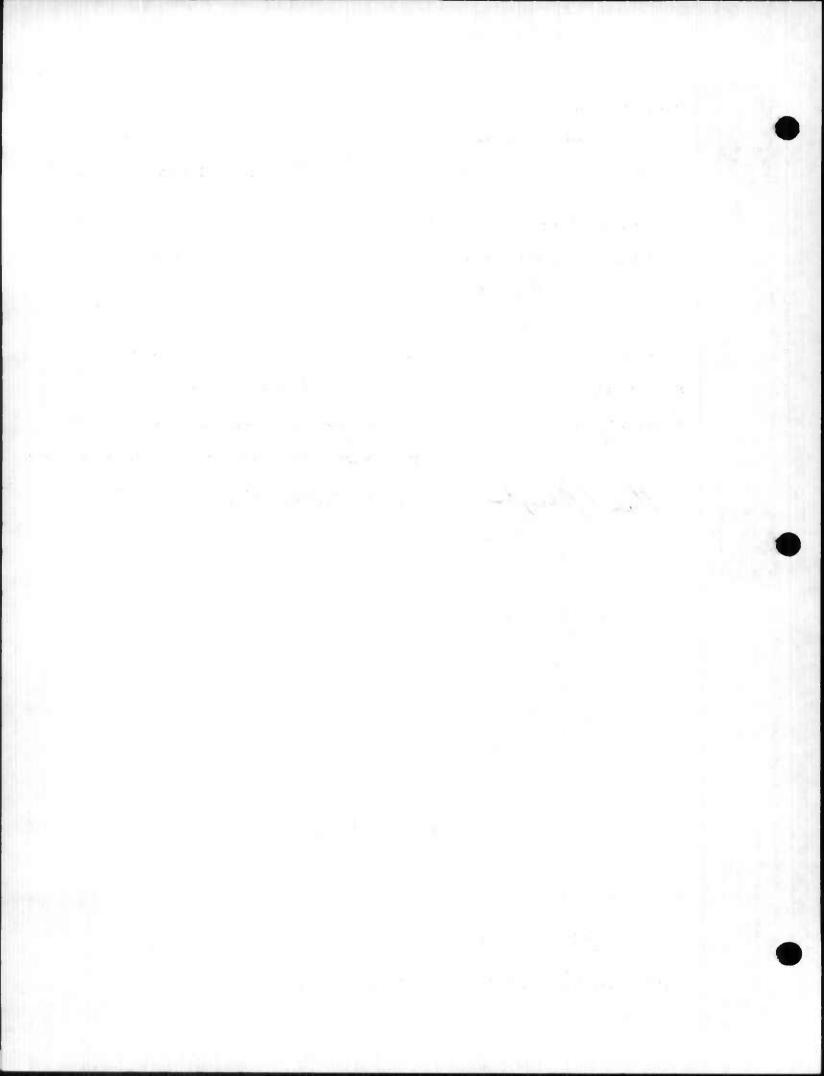
28b. Time of

28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State	of Marylar		artment of F rtificate of		Mental Hy	giene Reg. No.	8	17131
	Physici	an	1. Decedent's Name (First, Mide	dle, Last)					2. Date of De		Year_	3. Time the
	/Medi			eiler					Mayh	12 ^{ey}	1998	3:00PM
٩	Examir	er	4a. Fecility Name (If not institution The Memoria	on, give street end nu 1 Hospit	m <i>ber)</i> :al			4b. City, Town, or Easton	Location of Deet	4c. County Talb		
	Funeral Director		5. Sociel Security Number 187–12–8382	6. Sex 1 ☑ M 2 □ F	7. Age (In yrs. 83	lest birthdey) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly. Year) 1915	9. Birthple Count New Y	ece (State or Foreign ork, NY
	r 28a-1 show		Usuel Residence of Decedent 10a. State 10b. Count	ty	10c. Cit	y, Town or Lo	cetion			_	10	Od. Inside City Limits
	88-4 s	oto	Maryland Caro	line		Greensb						1 X Yes 2 No
	vith th	ă	10e. Street end Number				10f. Zip Code	_		10g. Citizen of	Whet Count	ry?
C.	eath w	eral	Maple Ave., Ma		ge, #5D redent Ever in U	C 12.1	2163		Casaibi Van os No	U.S.A.	ce - America	an Indian
Seller 15-0020	72 hours effer death with the Maryland naturel", or items 23s or 28s-1 show	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ Ma 3 □ Widowed 40 □ Divorce	Armed Formarried 1 ☐ Yes	orces? 2⊠No ive		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🖾 No	en, Mexican, Puer	to Rican, etc.)	Bla	ck, White, e	etc.
S-0-6	72 hours "natural",	ted	15. Decede	ent's Education		16e. Deced	lent's Usuel Occup	petion	aduta L	16b. Kind of B	usiness/Inde	ustry
aryland 2121	1 and 2 should be filed within 72 he Health end Mentel Hygiene. em 27 Is marked other than "natur ther traumatic event, the Modesa	Completed	(Specify only high Elementery/Secondary (0-12) 11, grad	cest grede completed) College (welde	kind of work done OO NOT use retire	dunng most of wo d)	orking	commer	cial	
d D	be filed itel Hygi d other event, I	Be Co	17. Fether's Name (First, Middle	e, Last)		WEIGE	. L	18. Mother's Ne	me (First, Middle			
xa lan	lid be lentel ked c	To B	Steve Seiler					Mary C	era Seil	er		
Alexan	d 2 should thend Men 7 is marke traumatic		19a, Informent's Neme/Reletion	nship (Type, Pnint)		19b. Mailir	ng Address (Street	end Number or R	urel Route Numb	er, City or Town,	, Stete, Zip (Code)
₹Σ	and 2 saith e		Veronica Woody			202	Snug Har	bour Dr.	Shalima	ar Flori	da 3	2579
Baltimore,			20e. Method of Disposition 1 □ Burial 2 □ Cremetion 4 □ Donation 5 □ Other (State	emetery, cren	sition (Name of netory or other ple		Dete 5/18/98	Greens		m, State Maryland
Balt	permit. Pages Department of Important: If It any Injury or once.		21. Signature of Funerel Service	e Licensee		F1	Name end Addresses & O. Box 1	Helfenbe	in Fune	al Home	, P.A	
			23a. Pert1. Enter the disease, or shock, or heen failure. Lis	or complications thet of st only one ceuse on	caused the deat	h. Do not ent	er the mode of dyi	ng, such as cardla	c or respiretory a	rrest,	1	Approximete Intervel Between
	Physician /Medical		Immediate Ceuse (Finel disesse or condition	1	D.	1	Carcinan	M	e to tet	le.		Onset end Deeth
	Examiner	10	resulting in deeth)	a	-	or es e conseq		Ge VI	(0)(0)			aurig
x 68760,	enificate be executed ling physician end e es the buriel-transit	Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initieted events resulting in death) Lest	c		or as e conseq						
. Box	death certific e attending p od for use es	sician/	Part II. Other eignificant condit	-	eath but not res	ulting In the u	nderlying cause gir	ven in Pert I.	23b. Did	tobacco use co	entribute to	the cause of death?
P.0	es that the de igned by the a be deteched	by Physician/M	1	is Thron		Car	avery 1	Arten		Yee 2□No	3 Prob	
Division of Vital Records,	r requir been s should	Completed b	Wo Cerebrova	scuber A	rec iden-	t , C) cycles	the Join		en eutopsy ormed?	com	re autopsy findings illeble prior to appletion of cause leeth?
Ä	0 4 5	E O	Diserve						1 🗆	Yes 20 No	10	Yes 2□ No
ita	ysician: The s certificate director, pag	Bec	25. Was case referred to medic examiner?	al				26. Plece of De	ath (Check only	one)		
> >	D 00 2	70	1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Ott	her: 4 \sum Nursing I	Home 5 ☐ Resi	dence 6 □Oth	ner (Specify))
n o	70 0 0		27. Menner of Death 1 ☑ Neturel 5 ☐ Pend	ling 28e. Dete	of Injury oth, Dey Year)	28b. Time of Injury	Wo		28d. Describe	how injury occur	red	
sio	Attending or death.	cati		tigation				Yes 2 □ No	006 1	D1 - 1 - 1 1 - 1		(D 14 1
Divi	or At efter Direc d in by	Certification:	4 Homicide deten	mined 28e. Place build	e of Injury - At hing, etc. (Specif	ome, tárm, str	eet, factory, office		City or To	Street end Numl wn, Stete)	per or Hurei	House Number,
	To the Hospital or Attendin within 24 hours efter death. To the Funeral Director: Aft completely filled in by the fur	edical C	29a. Certifier Certify (Check only one) 2 Medica	Ing Physician: To the il Examiner: On the b	e best of my kno esis of examine oner stated.	wledge, deeth	occurred et the tire restigetion, In my o	me, dete end pleco opinion, death occ	e, and due to the urred et the time,	cause(s) end modete end plece,	enner es ste snd due to	eted. the cause(s)
	To th To th comp	Me	29b. Signature and title of period	2/1-	Lo)	29c. Licens	se number		29d. Date signe	id (Month, D	Dey, Yeer)
		-	100	0	0 -			T 147 2		5/1	5/9	5
			30. Name end eddress of person M. Jeffrey Dentor	D				21636				
	Sta	te	31. Dete filed (Month, Day, Yee		Registrer's Signe							
	Registr	-	MAY 1	9 '98	June alder in	heridsen-l	Fanci					



29d. Date signed (Month, Day, Year)

MAY 18, 1998

Dey

Month

1. Decedent's Name (First, Middle, Last)

EDMUND

Funeral Director

with the Maryland o filed within 72 hours aftar death with the Marylan at Hyglene.

at Hyglene.

at Hyglene "neturet", or items 23s or 28s-f show yent, the Medical Energial Energy of the Medical Energial Energy of the Medical Energy of th permit. Pagas 1 and 2 should be f Department of Health and Mental I Important: If Itam 27 is marked of any Injury or other traumatic ave

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and s tha bunal-transit be axecuted daath certificata SS USB 0 tha datached that tha signed by requires peen aw. has page 2 The cartificata Physician: director, this

Mayle on May 17, 1998

Released

o Attending Division daath. 5

Aftar this Director: 5 24 hours a To the within 2 To the

MAY 17, 1998 5:15 P.M. 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 5501 CHRISTY DRIVE **BETHESDA** MONTGOMERY If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Days Months Hours Min. 1 X M 2 □ F Yrs. 75 BROOKLYN, N.Y. 067-14-0848 5, 1922 Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits MD MONTGOMERY **BETHESDA** 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5501 CHRISTY DRIVE 20816 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 20 Yes 2 □ No If Yes, Give Yeer or Detes: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. DEPT OF Cotlege (1-4or 5+) Elementery/Secondary (0-12) AGRICULTURE 4+ MANAGEMENT ANALYST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ARMAND SABATINI ERSILIA BUSACCHI 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5501 CHRISTY DRIVE, BETHESDA, MD 20816 GLORIA M. SABATINI WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Buriel 2 Cremetion 3 Removal from State GATE OF HEAVEN CEMETERY 5/21/98 SILVER SPRING, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Faheral Service Licensee 22. Name and Address of Facility
JOSEPH GAWLER'S SONS INC, 5130 WISCONSIN AVE. eters NW, WASHINGTON, DC 20016 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death Immediate Cause (Final CARDIOPULMONARY ARREST disease or condition resulting in death) 5 MINUTES Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE 5 YEARS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yee X No 3 Probably 4 Unknown HYPERTENSION þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed DIABETES MELLITUS - DIET CONTROLLED 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 X Neturel 5 Pending 1 ☐ Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

MD D 25113

3301 New Mexico Ave. NW #349, Washington, DC 20016-3622

State Registrar

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31. Date filed (Month, Dey, Yeer) MAY 2 0 1998

aurones

Lawrence Klein MD.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

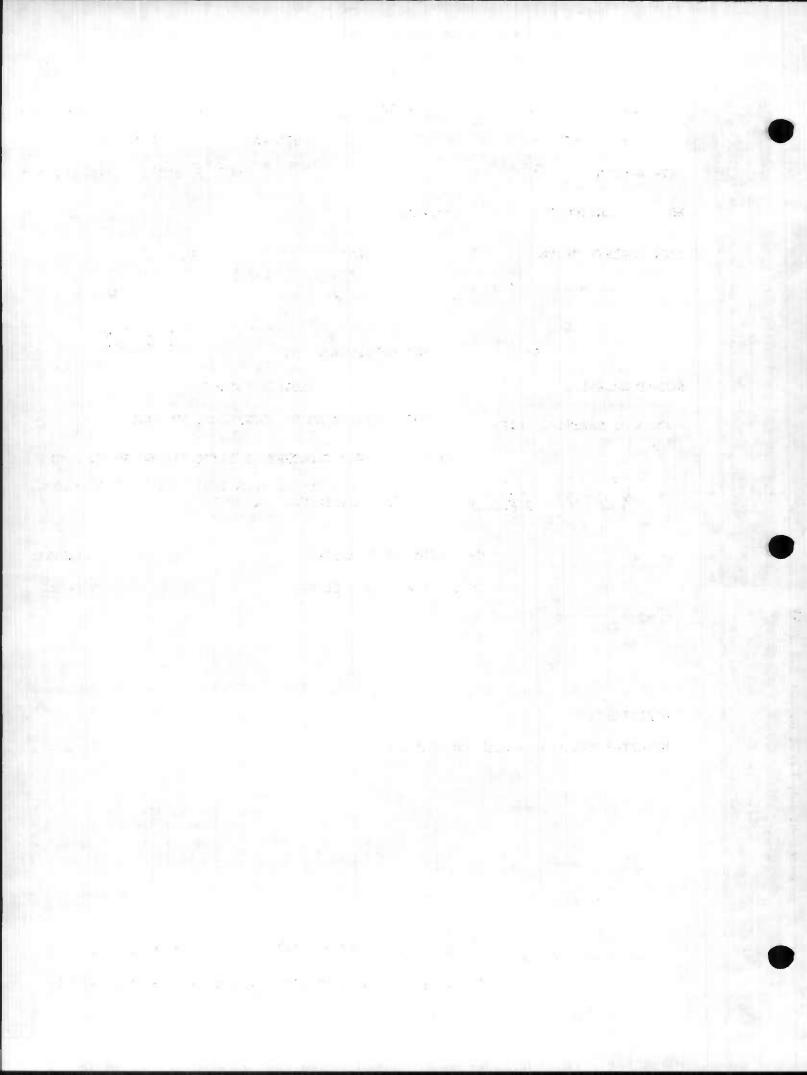
(Check only one)

29b. Signature end title of certifier

29e. Certifier

edical

32, Registrer's Signature Julia Davidson Randell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day 1:00 PM W. SAILSMAN MICHAEL 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 812 UNIVENSITY SIWER BNO. Mostonery 6. Sex 1 ☑ M 2 ☐ F If Undar 1 Yaar If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (SEP. 26, 1961 JAMATCA 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 36 Yrs. N/A Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 XXVo MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 812 UNIVERSITY BLVD. EAST APT. 9 20903 **JAMAICA** Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. 14. Raca - Amarican Indian, Armed Forces?

1 ☐ Yes 2 2 No
If Yes, Give
Yaar or Dates: Black, White, etc. Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 MECHANIC TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother'a Neme (First, Middle, Meiden Sumeme) LUSHINGTON SAILSMAN DAISY L. TUCKER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20903 19a. Informant's Neme/Relationship (Type, Print) 812 UNIVERSITY BLVD. EAST APT 9 SILVER SPRING MD DAISY L. TUCKER (MOTHER) 20a. Method of Disposition
1 ☐ Burial XX Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date FORT LINCOLN CREMATORY MAY 22,98 BRENTWOOD MARYLAND 4 Donation 5 Other (Specify) 22 Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licer 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2891 23a. Part. Enter the disease, or complications trial earlier the death. Do not once the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disaase or condition resulting in death) ACUTE MYOCALOIAL ENFARCTION Due to (or es a consequence of): ISOHOMIC MYOCKNOIAL WUPAST Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) thel initiated events resulting in deeth) Last Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were eutopsy findings available prior to complation of ceusa of death? 24a. Was an autopsy 1 Yas 1 ☐ Yes 20 No 25. Was cese refarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of 28d. Describe how Injury occurred 27. Manner of Death

Physician /Medical **Examiner**

certificate be execu Box 68760

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "netural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at

al Hygiene.

permit. Pagas 1 and 2 should be filt.
Department of Health and Mental Hy
Important: If Item Z7 is marked oth
any liqury or other traumatic even

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death with the Maryland

filed within 72 hours after

the attending physician and hed for use as the burial-transit signed by t

Examiner Physician/Medical by Completed Be 2 Certification: al or Attenuars after death.

29a. Certifie

(Chec one) 29b. Signat

edicai

1 Satural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number

PIKE, ROCKVIUE, MD 20852

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

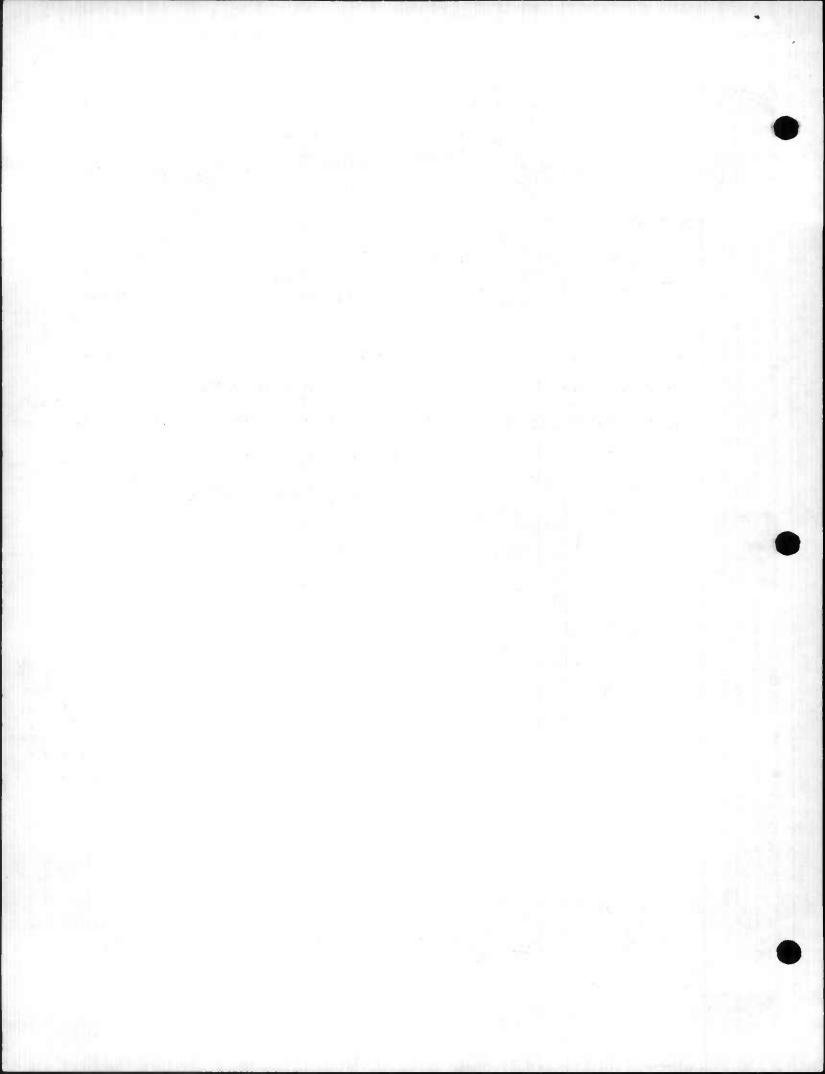
I. MALGOUS IND IINS POCECILE

31. Date filed (Month, Day, Year) MAY 2 2 1998

32. Registrar's Signeture Julia Davidson-Randalle

State Registrar

To the Hospital c within 24 hours at To the Funeral D complataly filled in



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death ^D 1998 Month **Physician** Arveh Samuel 18, May 10:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Mont. If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Deys 1 M 2 F 74 Yrs Director 571-52-9868 Feb. 19, 1924 Germany Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits show rai', or items 23a or 28a-f shov Examiner must be notified at Md. Mont. Wheaton 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10861 Bucknell Dr. 20902 US permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23, any injury or other traumatic event, in Medical Exercitor man Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemistry 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 0 Erna Balheimer 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Silk/ snl 946 Rosewood Ave. E. Lansing, Mich. 48823 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 12 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specifi Judean Memorial Gardens 5/20/98 Olney, Md. 22. Name and Address of Facility
Edward Sage1 Funeral 21. Signature of Funerel Service L Direction 1091 Rockville Pike Rockville, Md. 20852 Farth. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Physician/Medical Examiner + Meros cle the buriel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of) that initieted events resulting in deeth) Last Due to (or es e consequence of): 80 USe Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Ware eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28e. Dete of Injury (Month, Day Year) 27. Manner of Death funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending 1 Yes 2 No hours efter death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) me Silver spring Med 20902 Herman Georgia

10315

2. Pegistrer's Signature

Julia Dandson-Rendall

State Registrar

with the Maryland

Baltimore, Maryland 21215-0020

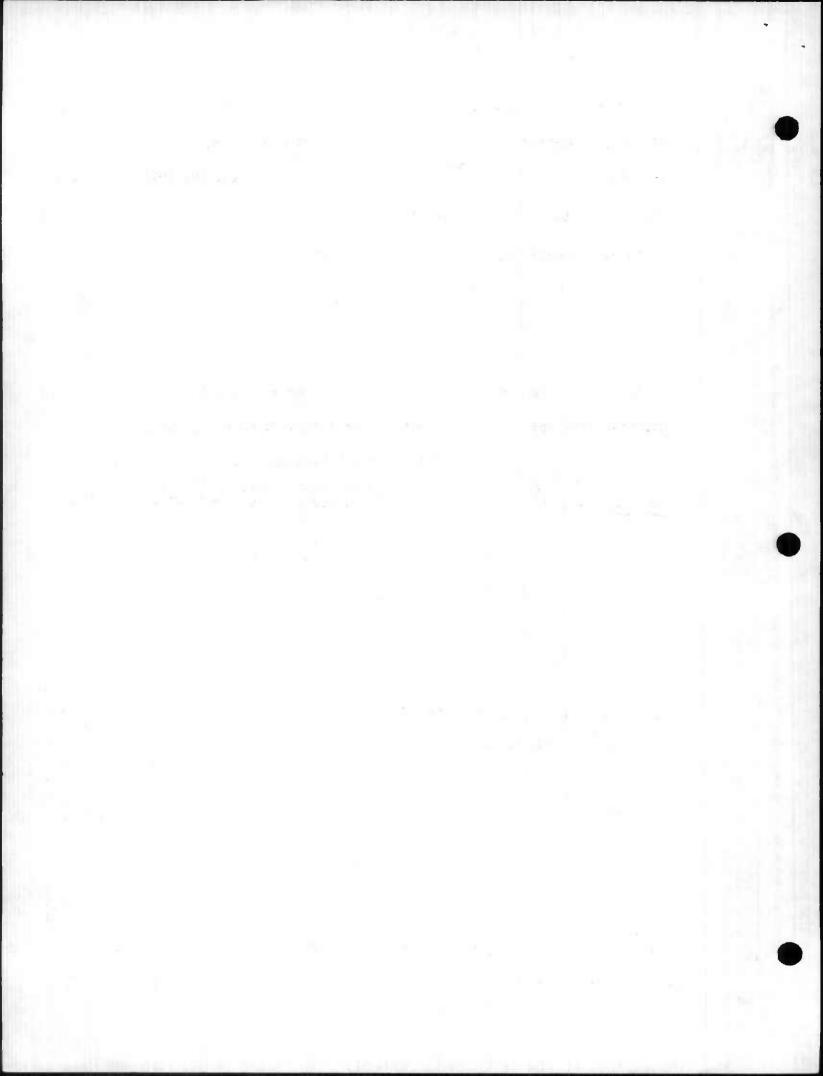
The law requires that the death certificate be executed

or Attanding Physician:

Hospital

20 10

Division of Vital Records, P.O. Box 68760.



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day Month Merle E. Severy May 13, 1998 2:30 PM 4a. Fecility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Data of Birth (Month, Dey, Year) 7. Age (in yrs. last birthdey) Birthpleca (Steta or Foreign Country) Days 150 M 2□ F Yes 75 058-14-3560 Aug. 3, 1922 California Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside Clty Limits 1 ☐ Yes 2 No Maryland Montgomery Chevy Chase 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7400 Bybrook Lane 20815 United States 12. Was Decedant Evar In U,S. Armed Forces? 1 ★ Yes 2 □ No If Yas, Giva Yaar or Detes: 13. Was Dacedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Bleck, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) National Geographic Elementery/Secondary (0-12) College (1-4or 5+) 5+ Editor/ Writer 17. Fether's Neme /First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Carlson Smith Enid Severy 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rure! Route Number, City or Town, Stete, Zip Code) Anne Overlin Severy/ Wife 7400 Bybrook Lane, Chevy Chase, Maryland 20815 20b. Pleca of Disposition (Nema of cemetery, crematory or other pleca) May 15, 1998 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 K Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Neme and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M00689 e, or complications that caused the deeth. Do not liter the mode of dying, such as cardiac or raspiratory arrast, List only ona cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel minutes disease or condition resulting in deeth) Ventricular Tachycardia Due to (or es e consequença of) Coronary Artery Disease years Due to (or es e consequence of) Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

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tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinal must be notified at

should be filed within 72 hours effer tond Mental Hygiene. marked other than "natural", or iter

permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If tem 27 ta marked other any injury or other traumatic event

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death

Examiner been signed by the attending physician end should be deteched for use as the buriel-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury Physician/Medical thet initieted events resulting in deeth) Lest

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To the Hospital
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Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

(Check only 29b. Signeture and title of certifier

1 🔯 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

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29c. Licanse number 29d. Data signed (Month, Day, Year)

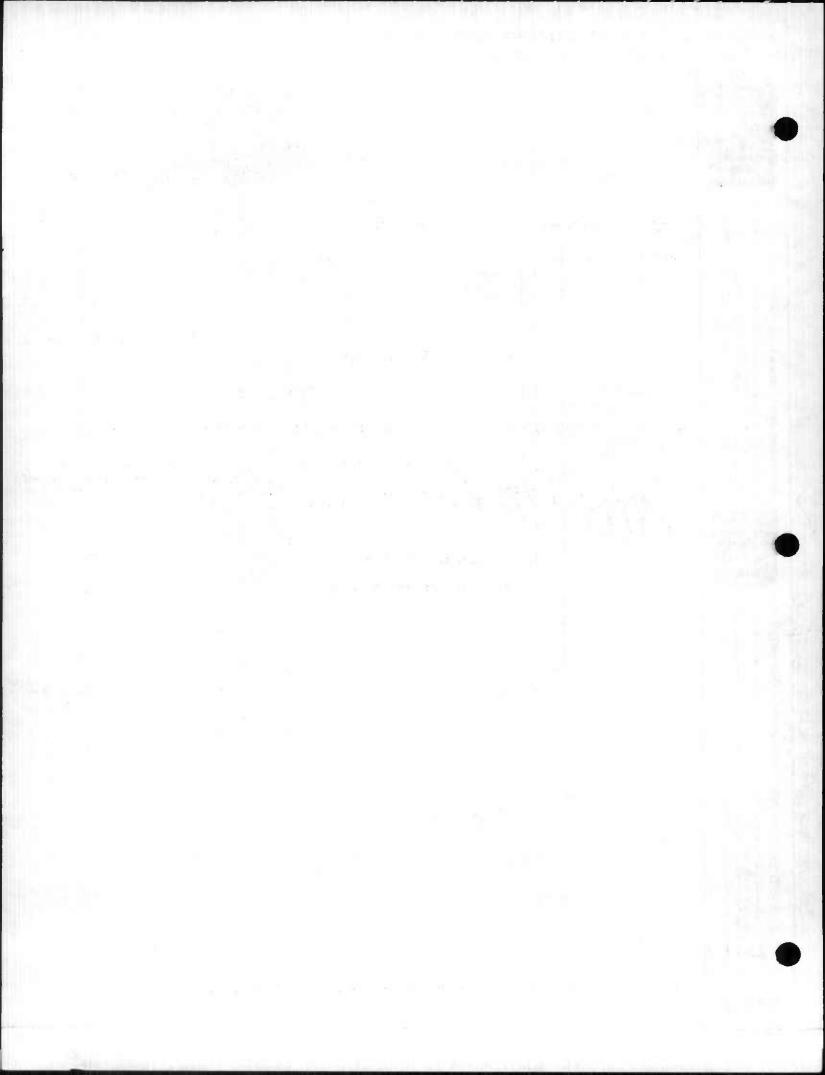
May 14, 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

R. Oskoui, M.D. 3301 New Mexico Avenue, NW, #202, Washington, DC 20016 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

Achia Savidson-Randelle MAY 1 8 1998



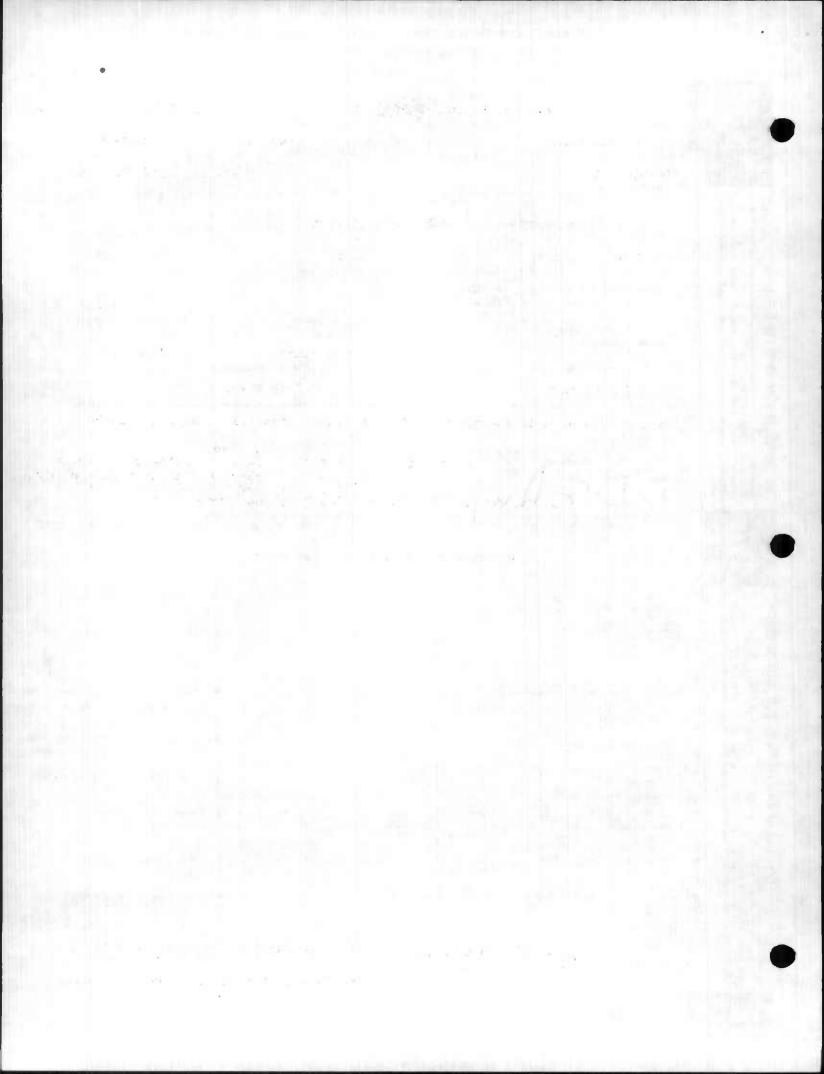
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Ob.,		1. Decedent's Neme (First, Middl	, Last)				2. Date of De Month		Vaar	3. Time of Death
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Exami		Holy Cross Hos	nital			C41 C		34		
Funeral		5. Sociel Security Number	6. Sex	7. Age (In yrs. lest birthd	(av) if Under 1 Yeer	Silver S	8. Dete of Bir (Month, De	MON th	tgome1	CY State or Foreign
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death with the Maryland me 23s or 28s-f show mass to a confident		10a. Steta 10b. County		10c. City, Town or	Location				10	d. Inside City Limit
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\$ 50 E	Director	10e. Street end Number	omery	DIIVEL	10f. Zip Code			10g. Citizen of 1	Whet Countr	rv?
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n 72	Completed	15. Deceden (Specify only higher	t grade completed)	(G	ive kind of work done e. DO NOT use retire	during most of wo	rking	16b. Kind of B	JSIN0\$\$/INQU	Istry
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Mental t Mental t arked or	Be					To. Motter's Ne	me (First, Middle,	, Maiden Suman	16)	
should be filed within and Mental Hygiene marked other than umatic event, tre M	2	Joseph H. Rep	•				E. Stamb		NAME OF THE OWNER O	
" = = 3		19e. informant's Neme/Relations	nlp (Type, Print)		eiling Address (Street					Code)
permit. Pages 1 end 2 Department of Health a Important: If item 27 is any injury or other tra odce.		Elsie Myers	(s	TSCCI/	0215 Highl	and Dr.,				
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		shock, or heart failure. List	only one cause on e	ech line,	ornor tria triodo or dy.	19, 5001100 001010	o or roophotory o	,,	: 1	Intervel Betwaen Onset and Death
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a tie	Examiner		b			use				- WEEKS
and al-tra	Xar	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury		Due to (or es e con	sequenca of):				į	
buri		Ceuse (Diseese or Injury	C							
ettending physician and for use es the bunel-transit	edical	thet initieted events resulting in deeth) Lest	ì	Due to (or es e cons	sequence of):					
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death certificate be axecuted e ettending physician and od for use es the bunel-transit	Physician/M									
0 0 0	ysi	Pert II. Other significant condition	ns contributing to de	ath but not resulting in the	e underlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to t	the cause of death
od by detec							1 🗆	Yes 2 No	3 Probe	ably 4 Unknow
5 5 8	by								T	
been si should I	Completed							an eutopsy med?	evei	re autopsy findings lieble prior to
hes by	pie									eath?
ate h	00						10	Yes 2 No	10	Yes 2□ No
this certificate he ral director, page	0	25. Was case referred to medical				26 Place of De	eth (Check only o			
direc	To B	exeminer?	Hospital:	npatient 2 ER/Outpa	tient 3 DOA Ott	ner _	doma 5 ☐ Resid		os (Cassiful	
五 種		27. Menner of Death	28e. Dete					how injury occur		
After funer	Certification:	1 Netural 5 Pendin	(Mont	h, Dey Year) Injur		rk? Yes 2⊡No				
within 24 hours efter death. To the Funeral Director: Affector of the fune completely filled in by the fune	Ica	3 ☐ Suicide 6 ☐ Could r	ot be	of Injury - At home, farm,			28f Location /	Street and Numb	ner or Rural	Poute Number
efter death. Director: A	T T	4 ☐ Homicide determ	ned buildir	ng, etc. (Specify)	street, rectory, office		City or To		or or rigital	riodio ridinoer,
within 24 hours efter d To the Funeral Direct completely filled in by		200 Codifice No. 14.1								
Fun Fun tely	edical	29a. Certifier 1 Certifying (Check only one) 2 Medicai I	xaminer : On the ba	best of my knowledge, de sis of exemination and/or	eath occurred at the till r investigation, in my d	me, date end plece opinion, deeth occu	e, end due to the urred et the time,	cause(s) and me date end placa,	and due to t	ted. the cause(s)
the mple	Me Me		end menn	er steted.	29c, Licens	no aumbos		Ond Data sinns	d /Month E	lau Vaad
₹ 2 8	-	29b. Signetura and title of cartifier	1 shilly	/				29d. Deta signe		ay, rear)
41		Caraen !	guar in the		D434	176		5-15	18	
п '		30. Neme end eddress of person	vho completed cause	e of deeth (Item 23e) (Typ	pe, Print)					
		MOHAMMAN A	KHALID .	Mp. 8830	Cambon C	ourt Sil	respons	mb 20°	310	
Sta	te	31. Dete filed (Month, Dey, Fear)	Jal He	egistrar's Signeture		* V			-	
Registr		MAY 18 1	198 Jul	egistrar's Signeture	lell					
			0							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

		· · · · · · · · · · · · · · · · · · ·			Cer	tificat	e of	Death		leg. No.	0.	1113
Physician		I. Decedent's Name (First, Middle	, Last)						2. Dete of Dee Month	Dey	Year	3. Time of Deeth
/Medical			Frances V:	irginia	May S	Smith			May 18	1998		6:20 pm
Examiner		a Facility Neme (If not institution,	giva street and num	iber)			4	b. City, Town, or	Location of Deeth	4c. County	of Death	- 1
	в	324 Seth Pla	ce					Rockvil	le	Montg	omery	
uneral	5	. Social Security Number		7. Aga (In yrs.	last birthday)	If Under		If Under 24 Hrs.		1	9. Birthple	ce (Stete or Fore
rector		214-01-9709 Usuel Residence of Decedent	1□ M 21 F	8	86 Yrs.	Months	Deys	Hours Min.	Mar. 24	, 1912	Mary	
ahow dat	1	10a. Steta 10b. County		10c. Ci	ty, Town or Lo	cation					10	d. Inside City Lim
F 8		Maryland Montg	omery	Roc	kville							TOM Yes 2LI
or 2		IOe. Street and Number				10f. Zip	Code		1000	10g. Citizen of V	Whet Count	ry?
23a		100 Charles St	reet			208	350			United	State	S
item 27 is marked other than "natural", or items 23a or 28s-1 ahow other traumatic event, the Medical Exercines must be notified at other traumatic event, the Medical Exercines must be notified at other traumatic event, the Medical Exercises To Be Completed by Funeral Director	1	1. Meritel Stetus 1. Nevar Married 2. Marri	if Yes, Give	ces? 2 🔯 No		Wes Deced f Yes, spec		lispenic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Rac Bled Specify	e - Amarica ck, White, e	tc.
do do		3 Widowed 4 □ Divorced	Year or Da	tas:							Whi	
ete dans		15. Decedent	s Education grade completed)		16e. Deced	ient's Usue kind of wo	nk done	etion during most of world)	rking	16b. Kind of B	usiness/indi	ustry
G G		Elementary/Secondery (0-12)	Coilege (1-	4or 5+)	1							
CO CE		12			Nurs	ing A	Assi	stant		Medica		
is marked other than "natural", raumatic event, the Medical Eas To Be Completed by		7. Fathar's Neme (First, Middla, L	ast)					18. Mother's Ner	me (First, Middle,	Meiden Sumen	10)	
To E		John Ira Lambe	rt					Grace B	oyer			
E I		19a. Informent's Name/Relationsh	lp (Type, Print)		19b. Meilir	ng Address	(Street	end Number or Ru	rei Route Numbe	r, City or Town,	Stete, Zip (Code)
ant: If item 27 is ury or other trac		Frances E. Schi	ldroth/Dat	ughter	324 S	eth I	Plac	e, Rockv	ille, Ma	ryland	2085	0
other to	-	20e. Method of Disposition		006 1	Diene of Diene	eition (Alon	no of		Dete	20c. Location -	City or Toy	m, Stete
	-	1 ☐ Buriel 2 ☐ Cremation	3 Removei from S	state	cametery, cren	natory or o	ther plac	ca/May 21,				
lury	-	4 Donetion 5 Other (Sp	ecify	Mor	ntgomer	y Cre	emat	orium, I	nc.	Bethesd	a, Ma	ryland
important: If any injury or poce.	1	21. Signeture of Funerel Service L	Consideration	4. MO	Ro	ckvi.	Lle,	ss of Fecility Ro Inc. 3 Marylan	00 West	Montgom	y Fundery A	eral Hom venue
	+	23a. Pert1. Enter the diseese, or shock, or heert failure. List of	complications that ca	used the deel								Approximete Intervel Between
i) physician and its the burial-transit edical Examiner		Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	b	Due to (d	or es a conseq or es e conseq or es e conseq	quenca of):						
igned by the attending phose detached for use as the detached for use as the by Physician/Med		resulting in deetin) Lest	d		· ·						1	
the att	F	Pert II. Other significent condition	ns contributing to de	ath but not res	sulting In the u	nderlying c	ause giv	ren in Pert I.	23b. Did 1	obecco ues co	ntribute to	the ceuse of dea
tache dache									1□	res ZXNo	3 Prob	ably 4 ☐ Unkn
signed by P P P P P		Diabetes										
should eted		Hypertension							24e. Wes perfo	en eutopsy med?	com	re autopsy finding liable prior to apletion of cause eeth?
e has age 2									10	es 2X No	10	Yes 2 No
O P		25. Wes case referred to medical						oc plans of Da				
is certificate ha director, page To Be Com	1	exeminer?	Hospital:		2000		Oth	-	eth (Check only o			
		1 Yes 2 X No 27. Manner of Deeth	1 1 1		ER/Outpetier		/A	4 La Indiania L	dome 5 Resid	lenca 6 ∐Oth now Injury occur		
e funer ation:	2	1 X Neturel 5 ☐ Pending Investig		f Injury n, Dey Year)	28b. Time of injury	M	8c. Injur Wor 1 🗌	yet k? Yes 2 □ No	28d. Describe i	low injury occur	Tea	
To the Funeral Director: After the completely filled in by the funeral Medical Certification:		3 Suicida 6 Could n 4 Homicide determi	ot be ned 28e. Pleca buildin	of Injury - At h g, etc. (Speci	ome, ferm, str	eet, fectory	, offica		28f. Location (S City or Tox	Street end Numl vn, Stete)	ber or Rural	Route Number,
pletely fill edical			Physicien: To the xaminer: On the ba	sis of examine								
		29b. Signetura and titia of certifiar		311/3		290	. Licens	e number		29d. Date signe	d (Month, D	Dey, Year)
Med Med	1 2			,		0	1 -	1) 121101		rl	15/0	0
To the Funeral completely filled Medical C	1	m. max	o no p	HAZIC	150	1	7 7	0 8 0 1		5 1	111	18
Tothe		30. Neme end eddress of person		ot deeth (Iter	m 23e) (Type,		7 2	0 8 00		5 1	1115	
To the comple			no completed cause	ot deeth (Iter	m 23e) (Type,		د د oule	evard, Ro	ckville,	Maryla	and 2	0852



Pleas

Please Type or Print in E State of Marylan						_	ible.	7100
		tificate d			,	Reg. No.	0	1138
's Neme (First, Middle, Last) BERTHA T. SPR	ING				2. Data of De Month MAY	eeth Dey	Yeer 998	3. Time of Death 1:30 AM
lame (If not institution, giva street and number)			4b. City,	Town, or L	ocation of Deet			
CIRCLE MANOR NURSING HOME			KEN	SING	ron		MONTY	GOMERY
0-7469 6. Sex 1 M 2 ₹ F 7. Aga (In yrs. 92	last birthday) Yrs.	If Under 1 You Months De		Min.	8. Date of Bir (Month, De NOV • 1	ey, Year)		plece (Stete or Foreign ntry)
ence of Decedent								
10b. County 10c. City MONTGOMERY	y, Town or Lo		INGTON				1	0d. Inside City Limits 1 ☐ Yas 2 ☐ No
and Number		10f. Zip Cod	le			10g. Citizen of	Whet Cour	ntry?
231 CARROLL PLACE			20895			U.	S.A.	
itatus 12. Was Decedant Ever in U, Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Giva Yeer or Detes:	If	Vas Decedent Yas, specify C □ Yas 2 ☑	Cuben, Maxic	an, Puerto	pecify Yas or No Ricen, etc.))- 14. Rad	ce - Americ ck, White,	
15. Decedent's Education (Specify only highest grade completed)	16e. Deced	ant's Usuel Ockind of work do	cupetion	et of work	ring	16b. Kind of B	usiness/în	dustry
y/Secondery (0-12) College (1-4or 5+)	life. L	OO NOT use re	tired)	, o	9		CHOOL	
Neme (First, Middle, Last)			18. Mot	her's Nam	e (First, Middle	, Maiden Sumer		
MORRIS COHEN				F	LATTIE	SA	NDMAT	4
ent's Neme/Relationship (Type, Print) REN J. KOTLER/SON of Disposition 20b. P	74	_	RE TU			ARLBORO	MD.	20772

Physician /Medical Examiner

The lew requires that the death certificete be axecuted

Division of Vital Records, P.O. Box 68760.

Immediete Ceuse (Final disaasa or condition resulting in deeth) Examiner buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last and ettending physician I for use as the burie

1 Decedent's Name /First Middle

4e. Fecility Name (If not institution.

5. Sociel Sacurity Number

133-30-7469

10a State

MD.

11. Marital Status

10e. Street and Number 10231

Director

Funeral

by

Completed

Be

2

Usuel Residence of Decedent

1 □ Never Marriad 2 □ Marrier

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signature of Funeral Services I consec

1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stata

3 XWidowed 4 ☐ Divorced

Elementery/Secondery (0-12) 17. Fether's Neme (First, Middle, La

19a. Informent's Neme/Relationship WARREN J. KOTI

20e. Method of Disposition

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic avent, Ita Marcial Example.

Baltimore, Maryland 21215-0020

Physician/Medical by Completed Be Medical Certification: To

detached for

94 signed by t

peed paga 2 has

director.

filled in by

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

	0
_	b
,	C

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest shock, or heart feilure. List only one cause on each line. der Due to (or es e consequence of)

M00091

20b. Plece of Disposition (Neme of cemetery, cremetory or other place)

CHAMBERS CREMATORY

Due to (or es e consequence of):

Due to (or es a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No

3 Probably 4 Unknown 24e. Was en autopsy performed?

1 Yas

5/19/98

CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD.

24b. Were autopsy findings available prior to complation of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

1 Yes 2 No Other: 4 Jurising Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 2 Accident 5 Pending Investigetion 1 Yes 2 No

6 Could not be determined 3 Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Telegraphysician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end menner es stated.

2 Medical Examinar: On tha bests of examinerion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the ceuse(s) end menner steted. 29a. Certifler 29b. Signatyre end titla of certifiar 29c. License number

34032

29d. Date signed (Month, Day, Year)

RIVERDALE, MD.

20910

Approximete Intervel Between Onsat and Death

eass

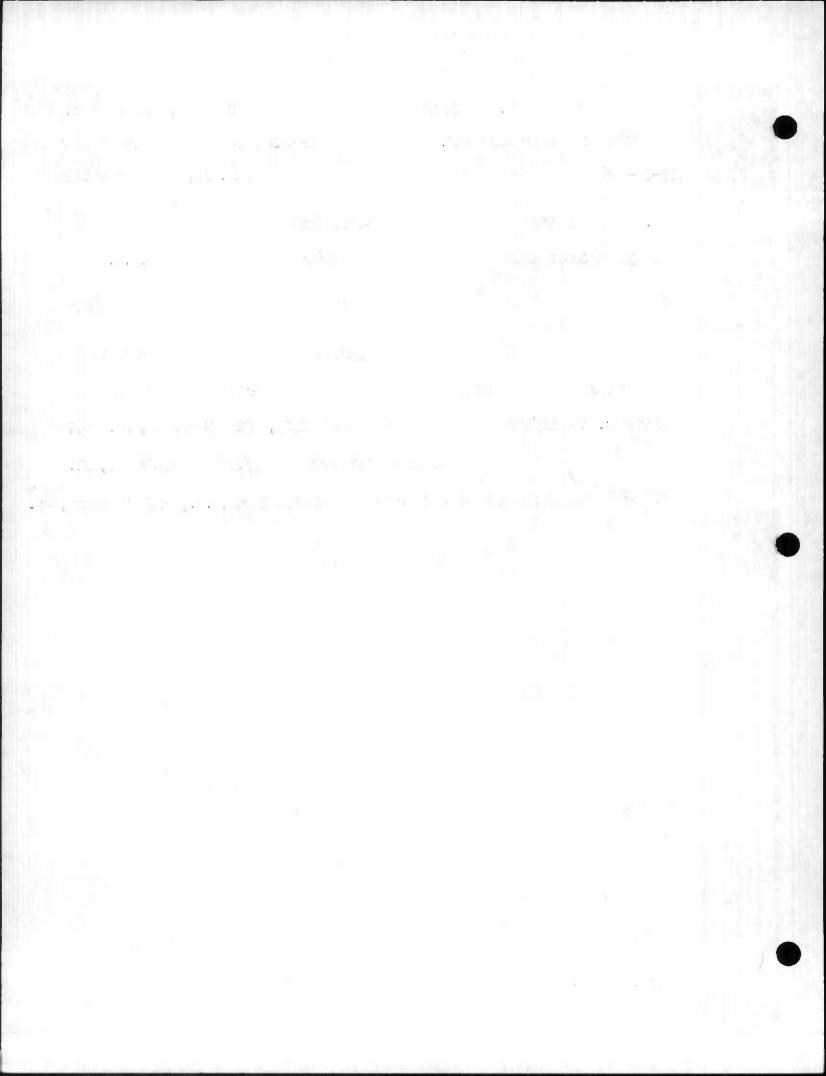
cause of deeth (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year)

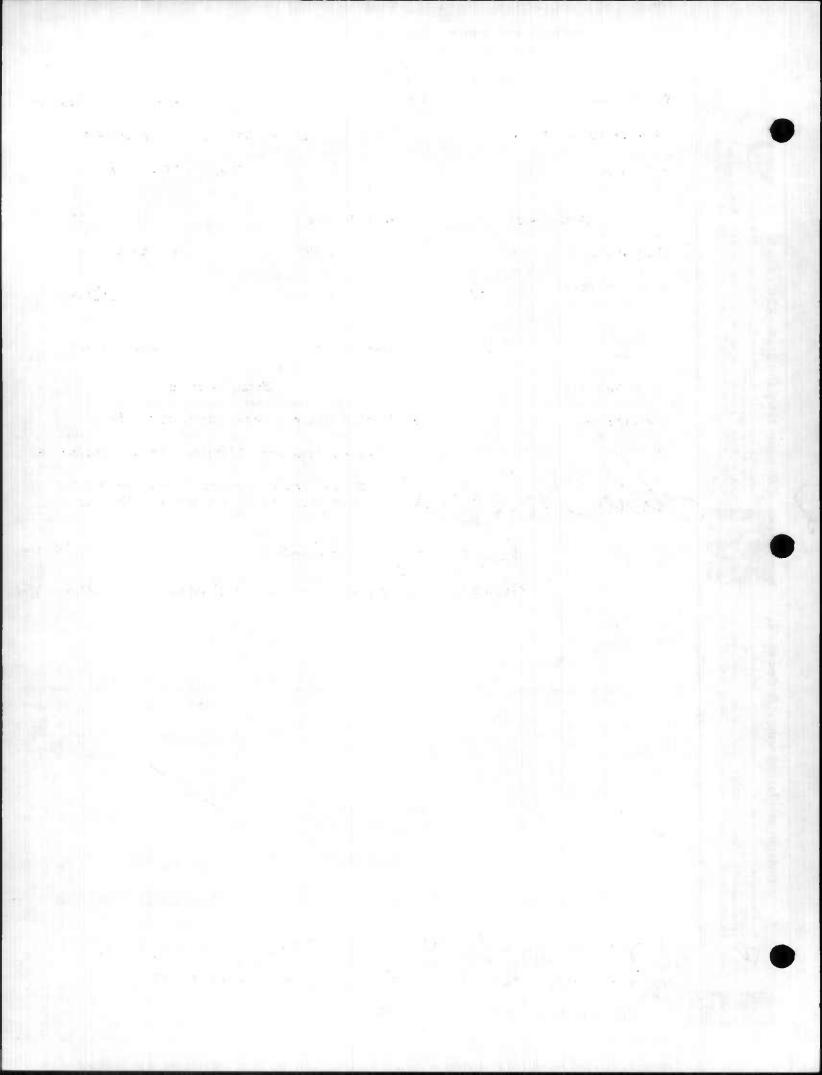
State Registrar

MAY 20

32. Registrer's Signeture Jula Davidson

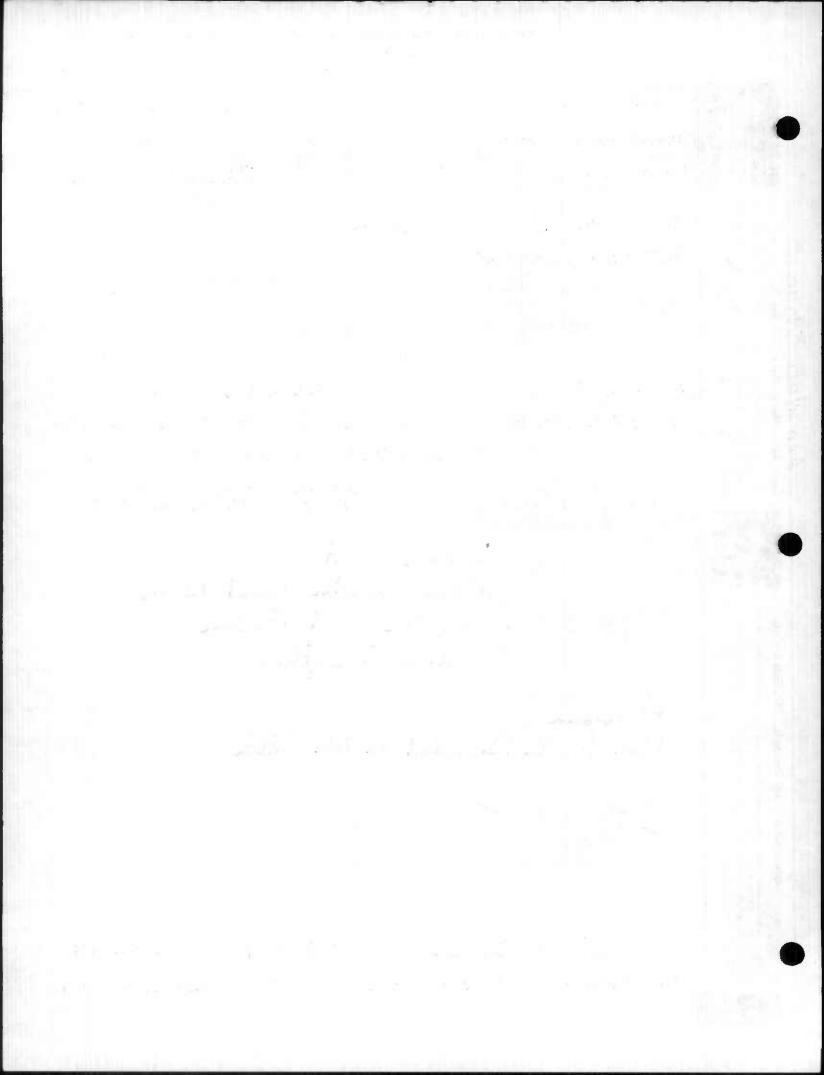


			State o	f Marylan		artmen ertificate				Mental Hyg	iene 9 {	3	7139
Т	Physician	1. Decedent's Name (First, Mid- Duk C. Sun	dle, Last)							2. Date of Deer Month May 15,	Day	Year	3. Time of Deeth 8:55 pm
Ŋ.	/Medical Examiner	4a Facility Name (If not instituti 3820 Woodrids		mber)			4			ocation of Death Spring	4c. County Mon	of Death	ery
	Funeral Director	5. Social Security Number 579–78–3901	6. Sex 1 → M 2 □ F	7. Age (In yrs. 1		Months	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey Feb. 8,	1924	9. Birthp Cour KO	place (Stete or Foreign ntry) rea
Mandand	and show	Usual Residence of Decedent 10a. State 10b. Coun MD M01	ntgomery	10c. City	y, Town or L	ocation .ver S	prin	g				1	10d. Inside City Limits
with the	3a or 28a-f si it be notified al Director	10e. Street and Number 3820 Woodrid	ge Avenue			10f. Zip	Code			1	Og. Citizen of '		
5-UUZU 72 hours after death with the Maryland	al', or items 23a or 28a-f show Examinat must be notified at by Funeral Director	11. Marital Stetus 1 Never Merried 2 🕅 Ma 3 Widowed 4 Divorce	Armed Fo	2 No	S. 13.	Was Decedif Yes, special				pecify Yes or No- Rican, etc.)	Ble	ck, White,	cen indian, etc. ental
V in	tr than the last was	15. Decede (Specify only high Elementery/Secondary (0-12) 12	ent's Education lest grade completed) College (1	-4or 5+)	(Give	dent's Usue kind of wor DO NOT us Contra	rk done d se retired	during mos	t of work	king	16b. Kind of B	usiness/in	
Maryland 2	Mentel H arked oth atic even	17. Father's Name (First, Middle Soon Yak Sui	•					18. Mothe		e (First, Middle, I		ne)	
Mar	lith end 27 is me r traum	19a. informant's Name/Relation Gun Sun/Son	nship (Type, Print)			_				ral Route Number nsington		, <i>State, Zip</i> 20895	
Baltimore,	nent of Hearn ret: If Item rry or othe	20a. Method of Disposition 1 Buriai 2 Cremation 4 Donation 5 Other		C	iace of Disp ametery, cre ate of	metory or o	ther piec	e) emete	ry	Date 5/18/98	20c. Location		own, State
P	20 0	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant condit	e. Res b. Met.	Due to (or	r as a conse	Hanter the mod	mpshe of dyin	ire Ag, such as	Ave	to Brace	pring,	MD	20904 Approximate interval Between Onset and Death 2-3 days 2-3 Months and Death
S, T.C.	gned by the be detached by Phys	Pan II. Other significant condi	nons contributing to de	eath but not rest	uting in the	underlying c	ause givi	en in Parti		1 th	00 2□No	3 Pro	bably 4 Unknown
VICAL DECOLUS,										24a. Wes a perform	med?	av cc of	/ere autopsy findings vallable prior to pmpletion of ceuse death?
lai The	certificate he rector, page	25. Was case referred to medic examiner?	ai					26. Place	e of Dee	th (Check only or		11	☐ Yes 2☐ No
5 4	this aldin	1 Yes 2 No		-	ER/Outpatie		Oth Bc. injun	4 🗆 190	ursing H	ome 5 Reside			fy)
DIVISION	within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Sulcide 6 Coui	d not be 28e. Place	of injury th, Dey Year) of injury - At ho ng, etc. (Specify	injury ome, farm, s	М	1 🗆	k? Yes 2□	No	28f. Location (S City or Town		ber or Run	al Route Number,
Hospita	in 24 hours in 24 hours in the Funeral I upletely filled		ring Physician: To the at Examiner: On the be end men										
Tothe	V comb	29b. Signature and title of cartif	gel.	f. M	٦.	290	C. Licenso	9 25	0	2	9d. Date signe	7 /9	Dey, Year)
	State Registrar	30. Neme en address of person JAE S. CHUN 31. Dete filed (Month, Dey, Yee MAY 18	n who completed cause 947 (7) 32. R	e of death (item O A mn legistrar's Signa b Davidson	1 23a) (Type Marketture Randa	Print)	d.	Lan	har	m , M	2070	6.	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					aryland / Depa <i>Cer</i>	tificate of			ene 98	17	140
	Physic /Medi		1. Decedent's Nama (First, Middle, Las Ann Stine	1)				2. Deta of Death Month May 2		Yaar	Time of Death 5:12 AM
	Exami		4a. Fecility Nama (If not Institution, give Civista Medical (4b. City, Town, or Lo La Plata		4c. County of		
	Funeral Director		382-10-2198	7. Ag	a (In yrs. last birthday) 86 yrs.	If Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, 02-22-]	YearFeb.		(Stete or Foreign
	show	L	Usual Residence of Dacedant 10a. State 10b. County		10c. City, Town or Loc	cation					Inside City Limits
	ith the Mary or 28s-f sh	Funeral Director	MD. Charle		Cobb	Island 10f. Zip Coda	1	10	g. Citizan of W		1 ☐ Yes 2 🖰 No
	ath w	rai	16183 Cobb Isla			20625				USA	
020	72 hours efter death with the Maryland natural', or itema 23a or 28a-f show their Examiner must be notified at	by	11. Marital Stetus 1 Nevar Married 2 Merried XXWidowad 4 Divorced	12. Was Decedant I Armed Forcas? 1 Yas YN I If Yas, Giva Yaar or Datas:	Evar In U,S. 13. V	Vas Decedent of H Yas, specify Cuba	lispanic Origin? (Sp an, Maxican, Puerto Specify:	ecify Yes or No- Rican, etc.)		White, etc.	
Maryland 21215-0020	d within 72 hours jiene. r than "naturel!,	Be Completed	15. Decedent's Edu (Specify only highest grad Elamantary/Secondery (0-12)	ication le completed) Collaga (1-4or 5	1+)		pation during most of work d)	ing	6b. Kind of Bus	sinass/Industr	ry
d 2		e Co	17. Fathar's Nama (First, Middie, Last)		Bea	uticiar	18. Mothar's Name	e (First, Middle, M	Self	Emp 1	oyed
ylar	Menta Menta arked	To B	Thomas O'Kelley				Lou Lov				
	nd 2 shoulth end 27 is mu		19a. Informant's Name/Relationship (T) Harvey Stine, Jr				and Number or Run .ivery,		,		
Baltimore,			20a. Method of Disposition 1 Burial 2 Cramation 3 F 4 Donetlon 5 Other (Specify)	Ramoval from State	20h Bloom of Dienos	ition (Ahma of	Wayside	Det-	0-1	Oh T	0
Balt	pamit. Page Department of Important: If any injury or once.		21. Signature of Funaral Sarvice Licans	Colad I	100817 A	Name end Addra	ss of Facility Echols 567 La	Funeral	. Home	P.A.	
	Dhualaisa		23a. Part1. Entar the disaasa, or composhock, or haart teilure. List only o	icetions thet caused ne ceuse on each lin	tha daath. Do not ente	er the mode of dyir	ng, such as cardiac	or raspiratory arre	st,	App	proximate erval Batween isat and Death
	Physician /Medical Examiner		Immediata Cause (Finel disaasa or condition rasulting in death)	. Ce	ndea (ance ot):	-				
	sacuted and al-transit	Examiner	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury		Dua to (or as a consequ	Juance of):	i He	ent 1.	Lunc		
68760,	ficate be executed physician and as the buriel-transit	edical	causa. Entar Underlying Causa (Disaasa or Injury that initiated avants resulting In death) Lest	·	Dua to (or as a consequ	_ I tea	1-0 1-0	uluu			
Box	death certific e attending p d for use as	lan/M		d	audiai	Mul	ythus				
P.O. I	0 0 %	Physician/M	Part II. Other significant conditions con	ntributing to death bu	ut not rasulting in the un	darlying cause giv	an in Part I.				cause of death? y 4 Unknown
of Vital Records,	been sign should be	Completed by	Non Insul	In My	tubung	Dealet	is hell	24a. Was ar perform		availab	Butopsy findings pla prior to aton of causa
al Re	The ate h	Comp		·				1 □ Ya	s 2 X No		as 2 No
Vita	Physician: The this certificate ral director, pag	To Be	25. Was casa rafarred to medical axaminar? 1 Yas 2 No	Hospital:	nt 2□ER/Outpatient	3□ DOA Oth	28. Plece of Deet		-	r (Specify)	
n of	ng Phys fter this ineral di		27. Mannar of Death 1 ☑ Naturel 5 ☐ Panding	28a. Data of Injur (Month, Day	v 28b. Tima of	28c. Injur Wor		me 5 Reside 28d. Dascribe ho			
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			30. Nama and addrass of person who co	omplated cause of de	eeth (Item 23a) (Type. I		701000	1	2-	21-9	8
			Henry Burke, MD, 1	15-A La G	Grange Aven	ue, P.O.	Box 2539	, La Pla	ta,Mary	land 2	20646
	Sta		31. Data filed (Month, Dey, Year)	32. Registra	's Signatura	2.1.11					



William Skinner

		- 2	4 Daniel Ville III III III III III III III III III	- 1 - 1			Cer	tificat	e of	Death	1-5	Reg. N	lo.	, [/141
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	Examir Funerai	ner	4e. Fecility Neme (If not institution The Memo	, = (,	Hosp	ital ge (In yrs.	last birthdey)	If Under		If Under 24 h	aston drs. 8. Dete of	of Birth	Ic. County	Talk	oot ace (Stete or Foreign
Č.	Director		217-28-3660 Usuel Residence of Decedent			79	Yrs.				Sept	.5,19		ary1a	
	ter death with the Marylar items 23a or 28a-f show ner mart be notified at	Director	Maryland Caro				y, Town or Lo								d. Inside City Limits 1 ☐ Yas 2 🕅 No
	th with the 23a or 2		10e. Street end Number 2364 Henry Roa	d				10f. Zip					Citizen of W	het Count	ry?
020	6 6	by Funeral	11. Manitel Stetus 1 □XNever Married 2 □ Man 3 □ Widowed 4 □ Divorced	12. Wa Am ied 1 [is Decedent ned Forcas' Yes 2\(\) 'es, Give ar or Detes:	?	- 11	Vas Dece	dent of H cify Cuba	ispanic Origin? In, Maxican, Pu Specify:	(Specify Yes o earto Rican, ato	or No-	14. Reca		tc.
21215-0020	filed within 72 hours Hygiene. rther than "natural", ent, tre Mevicol Exa	Completed	15. Deceden (Specify only higher Elementery/Secondery (0-12)	t's Education of grede comp	_	5+)	16e. Deced (Give life. L	lent's Usu kind of wo OO NOT u	rk done	during most of	working	16b.	Kind of Bu	Blac siness/Indo	
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ary	2 should be and Menta is marked aumatic or	To	Roy Skinner 19e. Informent's Neme/Reletions	hlp <i>(Type, Pri</i>	nt)		19b. Maitin	g Address		Helen_ end Number or	Log Rurel Route N		or Town,	Stete, Zip (Code)
Baltimore, I	permit. Pages 1 and Department of Health Important: If item 27 any injury or other transcene.		David White 20e. Method of Disposition 1 Burial 2 Crametion 4 Donetion 5 Other (S 21. Signatura of Funaral Services	3 □Remove pecify)	of from Stete	Cap	oitol C	rema Name er Benni P.O.B	tory d Addre	ss of Fecility Lith Fur 687. Ea	5/22/9	08 Dow	ver, I	De.	3 m, Stete
	Physician		23a. Pert1. Enter the disease, or shock, or heert feilure. List	complications only one caus			h. Do not ente	er the mod	le of dyln	g, such es cero	liec or respiret	ory arrest,			Approximate interval Between Onset and Deeth
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	be executed sician and burial-transit	Examine	Sequentially list conditions,	b		Due to (or	r es e conseq	uence of):		lilor					years
68/60,	cate be ex physician a the burial	- CO	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events rasulting in deeth) Lest	c	Eng	Due to (or	r as a consequ	uence of):		ease d	V	defe	voleu	r	years
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0.0	t the dea by the al	Physician/Medic	Pert II. Other significant condition					, ,		en in Pert I.	23b.	Did tobac			the cause of death?
Ś	v requires that the death certificate been signed by the attending phys should be detached for use as the	þ	defeuera	am a	sicial	6	L 3	Sp	, W			Wes en eu		eve	e eutopsy findings leble prior to
Hecord	The lav ate has page 2	Completed									-		2) No	of d	pletion of cause eeth? Yes 2□ No
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	1 2 c	밌	one)		d menner st	ated.									ine codeo(s)
	To the Hospital or At- within 24 hours after of To the Funeral Direct completely filled in by	Med	one) 29b. Signature end title of certifia	an	a menner si	ated.			. Licens	e number	2 4	29d. [Date signed	(Month, E	Pey, Year)

Syed I Ali , M D , 506 Idlewild Ave., Easton, Maryland 21601

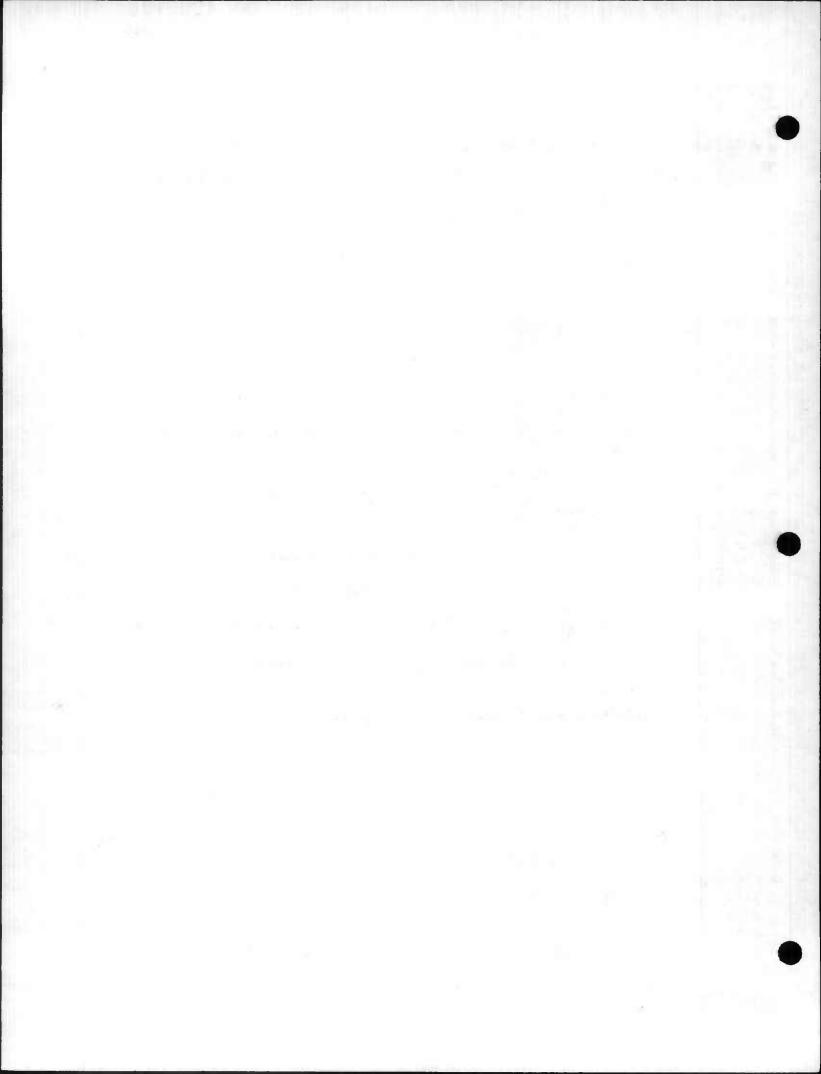
31. Dete filed (Month, Dev. Year)

MAY 2 2 1998

32. Registrar's Signeture

And Author Pandon

State Registrar



Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

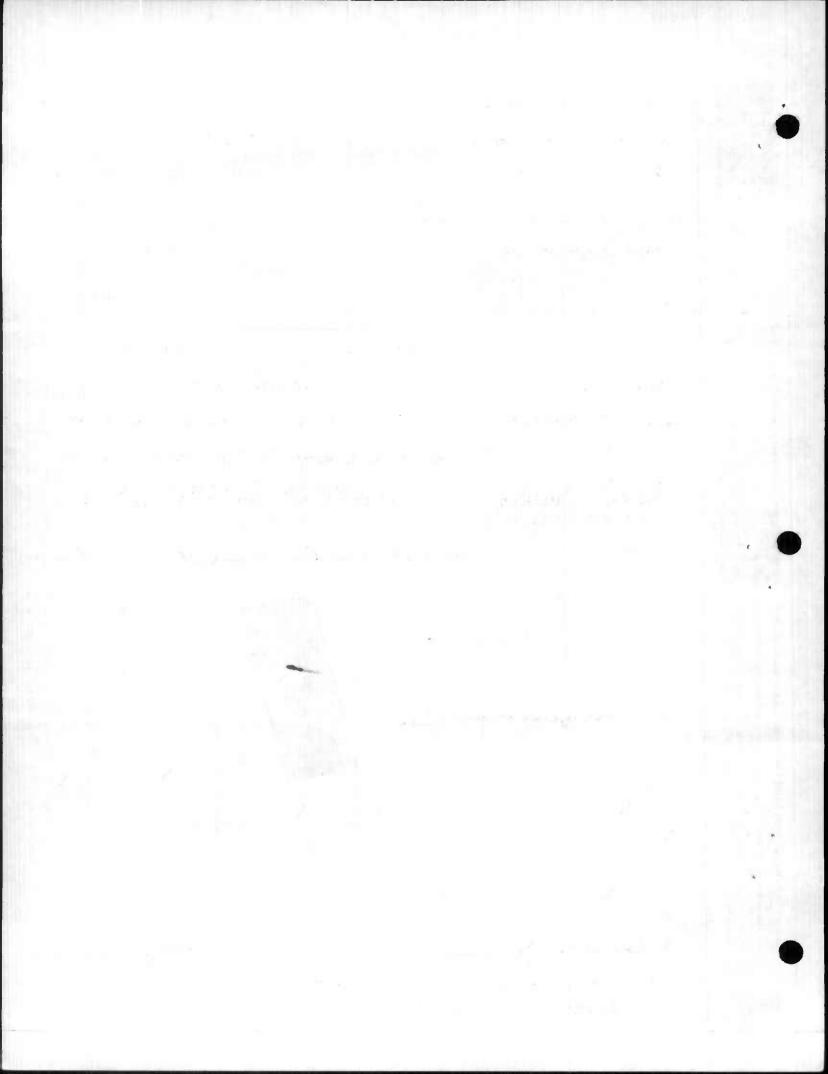
State of Maryland / Department of Health and Mental Hygiene

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MEMORIAL HOSPITAL @ EASTON EASTON TALBOT S. Social Security Number 6. Sex 7. Age (in yrs. last britriday) 1/2 Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 31, 1940 Mary land 10s. Street and Number 10s. State 10s. County 10c. City, Town or Location 10s. State 10s. County 10c. City, Town or Location 10s. Street and Number 26322 Oxford Road 10s. Street and Number 10s. Street and Number 26s. Street and Number 26s. Street and Number 26s. Street and Number 26s. Street and Number 25s. Street 10s. Street and Number 25s. Street 10s. Street 10s. Street and Number 25s. Street 10s. Street 1	ete or Fo		
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B DIABETES			
24a. Was an autopsy 24b. Were auto			
Page 24a. Was an autopsy performed? 24b. Were auto available prompletion of death?	4 □ Unk		
of death?	4 Unk		
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of death? 1 Yes 2 No 1 Yes 25. Wes case referred to medical examiner? 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 Mapatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	4 Unk		
Pospital: 1 Propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	4 Unk		
28a. Dete of Injury 28b. Time of Injury at Work?	4 Unk		
2 Accident Investigation M 1 Yes 2 No 3 Suicide 6 Could not be 38.0 Place of Injury. At home form effect factors office.	4 Unk		
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© 29b. Signature and be operating. 29d. Date signed (Month, Day, Ye	4 Unk psy findir fior to of cause 2 No Number,		
8 - 130. Squad & - H 41416 05/21/98	4 Unk		
# 41416 05/21/28	4 Unk		
30. Name and address of person who completed carrier of death (Item 23a) (Type, Print)	4 Unk psy findir prior to n of cause 2 No Number,		
John R. Condit, Jr., M.D. 403 Marvel Ct., Easton, Md. 21601	4 Unk psy findir prior to n of cause 2 No Number,		
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S Regist

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Physic	lan	1. Decedent's Name (First, Middle, Last)							2. Date of Dea	Day Year		3. Time of De	
/Medi		Helen Dorcas	Stover						May	24 1998 2:1			PM
Examir	ner	4a. Facility Name (If not institution, giva street end number)						City, Town, or Location of Death 4c. County of Death					
3		Mariner Health of Forest Hill						Forest Hill Harford					
Funeral Director		5. Social Security Number 216-28-0785 6. Sax 1 Months 1 M								, 1911	Coun	iaca (State or F try) yland	oreign
d within 72 hours effer death with the Maryland glene. years "neturel", or fems 23e or 28e-f show then "neturel", or fems 23e or 28e-f show the Medical Examination of the Medical Exa		10a. State 10b. County	10c. City, Town or Location								1	0d. Inside City I	Limits
	ctor	MD Baltim	ore	re Baltimore									X) No
	Funeral Director	10e. Street and Number 8304 Overmon	10f. Zip Code t Road 21234						10g. Citizen of What Country? U.S.A.				
	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?	1 ☐ Yes 2 🔼 No If Yes, Give 1 ☐ Yes 2 🕅 N				of Hispanic Origin? (Specify Yas or No- uban, Mexican, Puerto Rican, etc.) Io Specify:			o- 14. Race - American Indian, Black, Whita, atc. Specify: White		
	To Be Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Waitress				occupation fone during most of working retired)			16b. KInd of Business/Industry Food Service			
al Hygie other	S	17. Fathar's Name (First, Middle, Last)					18.	Mother's Name	ne (First, Middle, Malden Sumeme)			VICC	
ss 1 end 2 should b of Health and Ment Item 27 is marked other traumstice	o Be	Charles Skipp	er						Ensor				
	-	19a. Informant's Name/Relationship (7			19b. Maili	ng Address (S	Street end N	lumber or Run	al Route Numbe	er, City or Town,	State, Zip	Code)	
		William R. Sto	ver/Son	_				t Rd.,	Balti	imore,	MD 2.	1234	
		20a. Method of Disposition 1 ◯ Burial 2 □ Cramation 3 ☒ 4 □ Donation 5 □ Other (Specify				sition (Neme matory or other dom Cer		May Y	7 28, 1998	20c. Location -			
permit. Pege Department of Important: If any injury or once.		28 Signaffere of Funezal Service Licen	sedrib		22	Name and	Address of B	Facility Instei	n Mort ew Fre	uary,I	nc.	349	
		23a. Part1. Enter the disease, or comp shock, or heart fallure. List only	tions that caused	d the deatl	n. Do not ent	er the mode	of dying, suc	ch as cerdiac	or respiratory ar	rest,	1	Approximate interval Between	en
Physician			1 10								1	Onset and Dea	ath
/Medical Examiner	Н	Immediate Cause (Final disaase or condition resulting in death)	a (ine	bet	van	rule	when werelet				46 mo	NTN
	-	, ,		Due to (o	ras a consec	quence of):							
uted d ensit	Examiner		b	Due to /o		wanaa afti					i		
exac en en rial-tr	Еха	Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events		Due to (or as a consequence of):									
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death cer e ettendir ed for use	lan/		d										
icien: The law requires tr	by Physician/N	Part II. Other algnificent conditiona co	ntributing to death but not resulting in the underlying cause given in Part I.						23b. Did t	23b. Did tobecco use contribute to the cause of			death?
		Serge	ue disording					1 🗆 '	res 20 No	3 Prot	pably 4 □ Un	known	
	Completed								24a. Was perfo	Vas an eutopsy enformed? 24b. Were auto available completio of death?		ailable prior to mpletion of ceu	
	Be Com								101	es 2 No	10	Yes 20 No	0
		25. Was cese referred to medical examiner?	20.1 Rose of South Correct only one)										
	6	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatier				ma 5□ Rasio			1)	
Attending Physical Street After this by the fundrated	ation	27. Manner of Death 1 Natural 5 Pending 2 Accidant investigation	(Month, Da	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No						now Injury occur	red		
tal or Attendiins äfter death.	Certification	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)						fice 28f. Location (Street end Number or Rural Route Number, City or Town, State)					
To the Hospital within 24 hours to To the Funeral I completely filled	edical	29a. Certifier (Check only one) 1 Cartifying Phy	raician: To the best iner: On the basis of and manner st	examinat	wledge, death tion and/or In	n occurred at vestigation, in	he time, da my opinion	ite and place, , death occurr	and due to the deed at the time,	cause(s) and made date and place,	anner as st and due to	ated. the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier				29c. L	icensa num	nber		29d. Date signe	d (Month,	Dey, Year)	
		Davels	Dun			S.	32.	257		may 25, 1578			
	l f	30. Name and eddress of person who o	ompleted cause of d	eath (Item	23a) (Type,	Print)				0		. 0	
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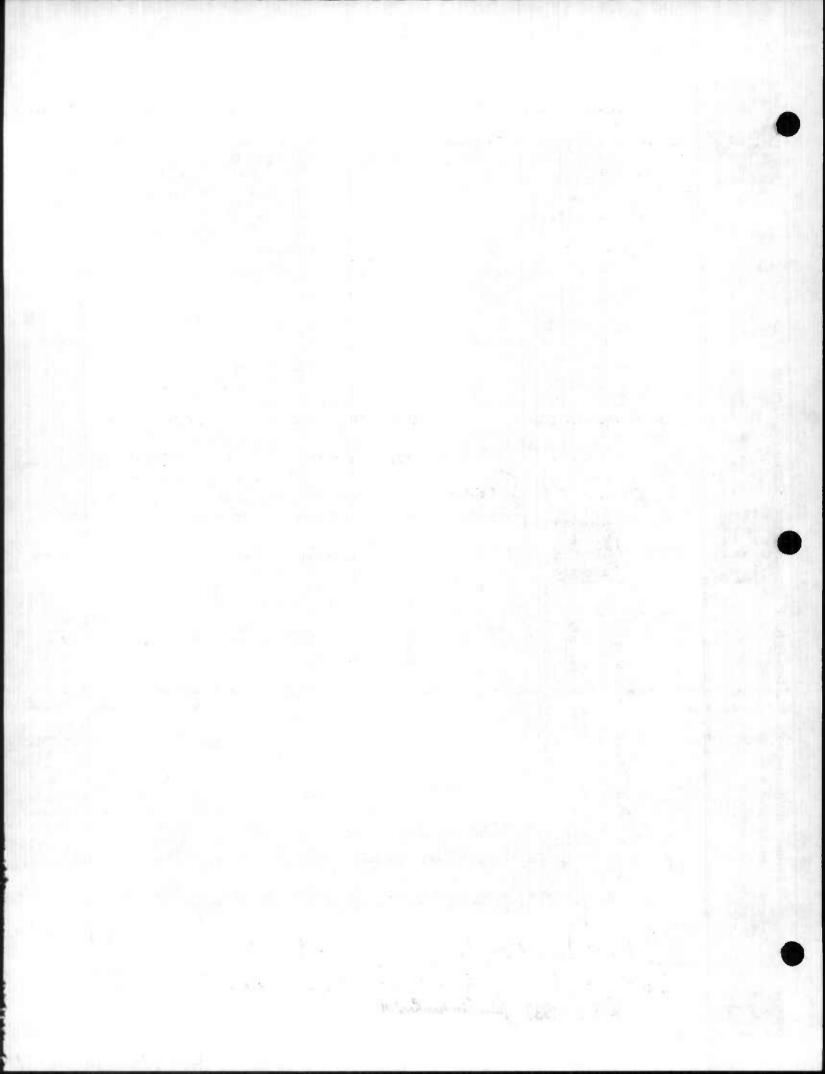
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Daeth 3 Time of Deeth Physician Month Dey DOROTHY PEARL SCHAUB 16, 1998 MAY 2:25 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WESTMINSTER NURSING & CONVALESCENT CENTER WESTMINSTER CARROLL 8. Date of Birth (Month, Dey, Year) JUN 12,1916 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplece (Stete or Foreign **Funeral** Months Deys Hours 1 □ M 2 ☑ F Director 218-40-2066 Yrs MARYLAND 81 Usuel Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Locetion 10d. Inside City Limits man be notified at BATIMORE Director MARYLAND **UPPERCO** 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 17728 FALLS ROAD 21155 USA Funeral Heme 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indien. the Medical Examiner Bleck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2♥ No If Yes, Give Yeer or Detes: 21215-0020 ò 1 ☐ Yes 2 ☐ No Specify: À Specify: 3 ☐ Widowed 4 ☐ Divorcad "natural", WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elamentery/Secondary (0-12) Collega (1-4or 5+) GROCERY STORE OWNER 12 other permit. Pages 1 and 2 should be file Department of Health and Mental Hyg. Important: If item 27 is marked ortany lours or other. traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surneme) Be ELMER L. CREAGER MAZIE M. STAMBAUGH 19e. Informant's Neme/Relationship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) JOHN E. SCHAUB, SON 2100 COUNTRY FAIR LANE, SYKESVILLE, MD 21784 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) BLUE RIDGE CEMETERY 5/20 THURMONT, MD 21. Signeture of Fyrnerel Service Licensee 22. Name end Address of Fecility -0 ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23e. Pert1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediete Ceuse (Final disease or condition rasulting in deeth) Examiner (or es a consequance of) Examiner manus The law requires that the death certificate be executed pue use as the burial-tran Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseasa or injury Due to (or as a consequence of): Box 68760. signed by the attending physician d be detached for use as the buria ScV Physician/Medical that initieted evants resulting in deeth) Lest Due to (or as e consequenca of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown 1 Yes Division of Vital Records, g cate has been signated page 2 should b Completed 24e. Wes an eutopsy performed? 24b. Were autopsy findings evalleble prior to completion of cause of daeth? certificate has 1 Yes 2 00 No 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case rafarred to medical 26. Pieca of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this 27. Menner of Deeth 28e. Deta of injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 5 Panding investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28a. Pleca of Injury - At home, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homleida Hospital Certifying Physician: To the best of my knowledga, deeth occurred et the tima, date end pleca, end due to the cause(s) end menner as steted.

Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 30. Nam

31. Dete filed (Month, Dey, Yeer)

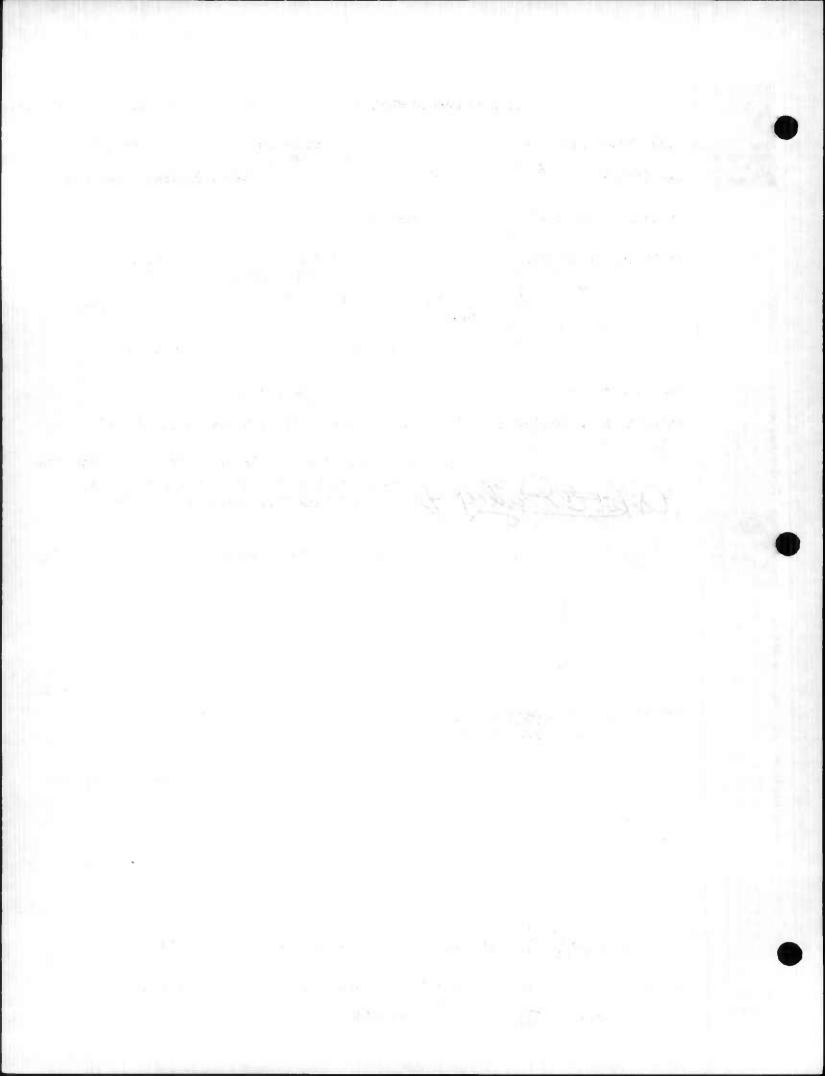
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State of Maryland / Department of Health and Mental Hygiene

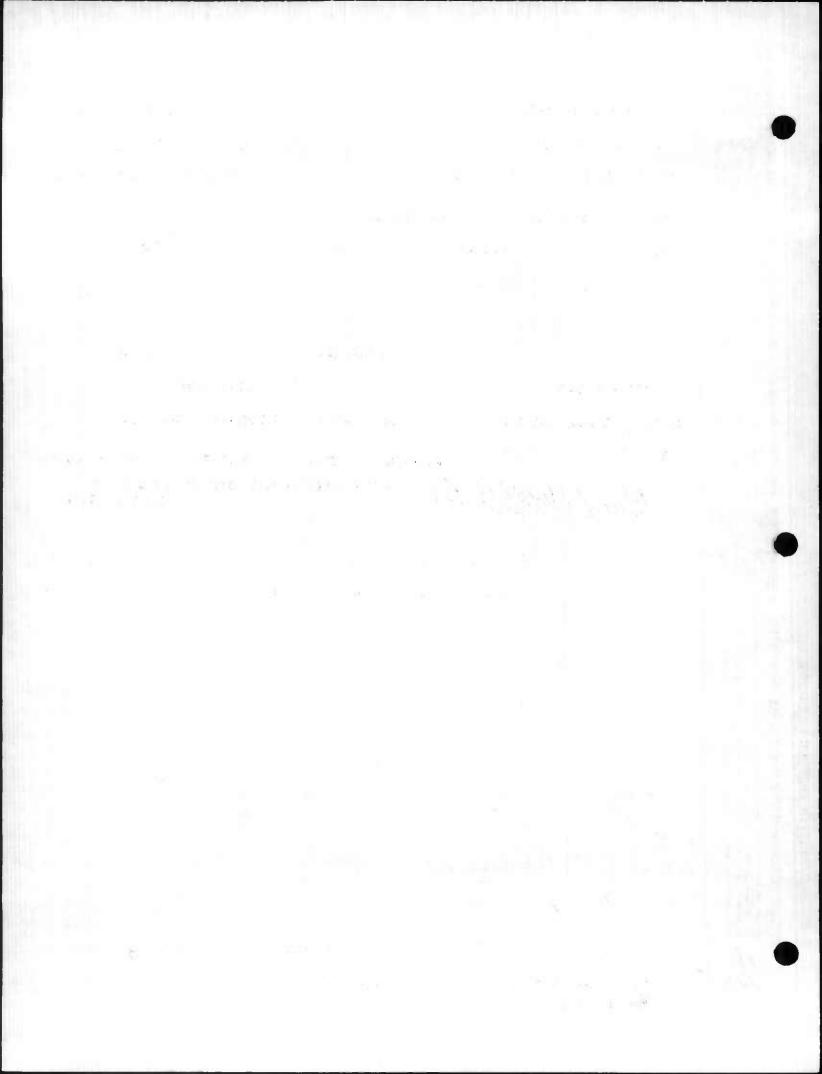
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month May 15, 1998 PAUL VERNON SINGLETON 3:15 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11537 Taneytown Pike Emmitsburg Frederick If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. Director 214-44-6150 Sept. 9, 1946 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shot treumstic event, the Medical Examiner must be notified at Frederick 1 ☐ Yes 2 No Maryland Emmitsburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11537 Taneytown Pike 21727 daath U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours aftar d Department of Haalth and Mental hygiena. Important: if Item 27 is marked other than "natural" or iten any injury or other treumatic event, tre Madical Examina. 1 ∑ Yes 2 No If Yes, Give Vietnam Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Gulf War Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Carpenter C&O Canal 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Roscoe Singleton Elnora V. Monn 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Wilhelmina E. Singleton (Wife) 11537 Taneytown Pike, Emmitsburg, MD 21727 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burlal 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/19/98 Frederick, Maryland Resthaven Mem. Gardens 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 Do not enter the mode of dying, such as cardiac or respiretory arrest, Onset end Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) METASTATIC SMALL CELL LUNG CANCER 16 MONTHS Examiner Due to (or as a consequence of) Examiner physician and the bunal-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or es e consequenca of). P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? SYNDROME OF INAAPROPLIATE SECRETION OF To Yes 2 No 3 Probably 4 Unknown Records, þ AND DIURETIC HORMONE (SIADH). should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yes ZNo 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25€No 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1) Naturai 2 Accident To the Hospital or Attending within 24 hours after death.
To the Funerel Director: After completely filled in by the funs. 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) Connol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian M. O'Conner, MD 501 West 7th Street, Frederick, Maryland 21701 9 1998 July always Randall 31. Date filed (Month, Day, Year) State Registrar MAY 1



Registrar

						Certifi	cate of	Deati	h		Reg. No.		1110	
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withir To th	Me	29b. Signature and	titla of certifier	1/			29c. Licer	se number	r		29d. Date sign	ad (Month,	Day, Year)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAY 10 1998 Anne Marie Stevens 08:40 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Sacred Heart Hospital Allegany Cumberland 5. Social Security Number If Under 1 Year If Undar 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 200 F Months Days Hours Min 215-84-0996 Yrs. Director AA Newfoundland 21-Apr-54 Usual Residence of Decedent with the Maryland 10e State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 le marked other than "naturel", or frems 23a or 28a-f ehow other treumstic event, the Modical Examiner must be notified at Yes 2 No Director Maryland Allegany Frostburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 145 South Water Street 21532-U.S.A. Funeral death 12. Was Dacadant Ever in U,S. Armed Forces? 1 ☐ Yas 2 M No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Pagas 1 and 2 should be lited within 72 hours after or ant of Haalth and Mental Hygiana. nt: If Item 27 te marked other than "naturel", or Item 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middla, Last) John R. Hartley Anna M. Quilty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kenneth Stevens Husband 145 Water Street Maryland 21532-Frostbura 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 Burlal 2 ☐ Cremation 3 ☐ Ramoval trom State Injury or Department of Important: If 4 ☐ Donation 5 ☐ Other (Specify) Zion Methodist Church Cemetery 13-May-98 Route 40, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Liquid eny Chu? Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ant 1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwaen Onsat and Death **Physician** /Medical 4 Weeks Immediate Causa (Final metastatic cam cancer disaase or condition resulting in death) Examiner Examiner physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be axec Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequence ot): usa signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown À 24b. Were eutopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? has paga 2 1 Yes 2 No cartificata 1 Yes 2 No or Attending Physician: funaral director, 25. Was cese reterred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA Phis 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Naturat 5 Pending aftar death. Director: Af 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital of 24 hours a Funeral D edical 1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examineation end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the F within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and title of cartifiar 29c. Licansa number

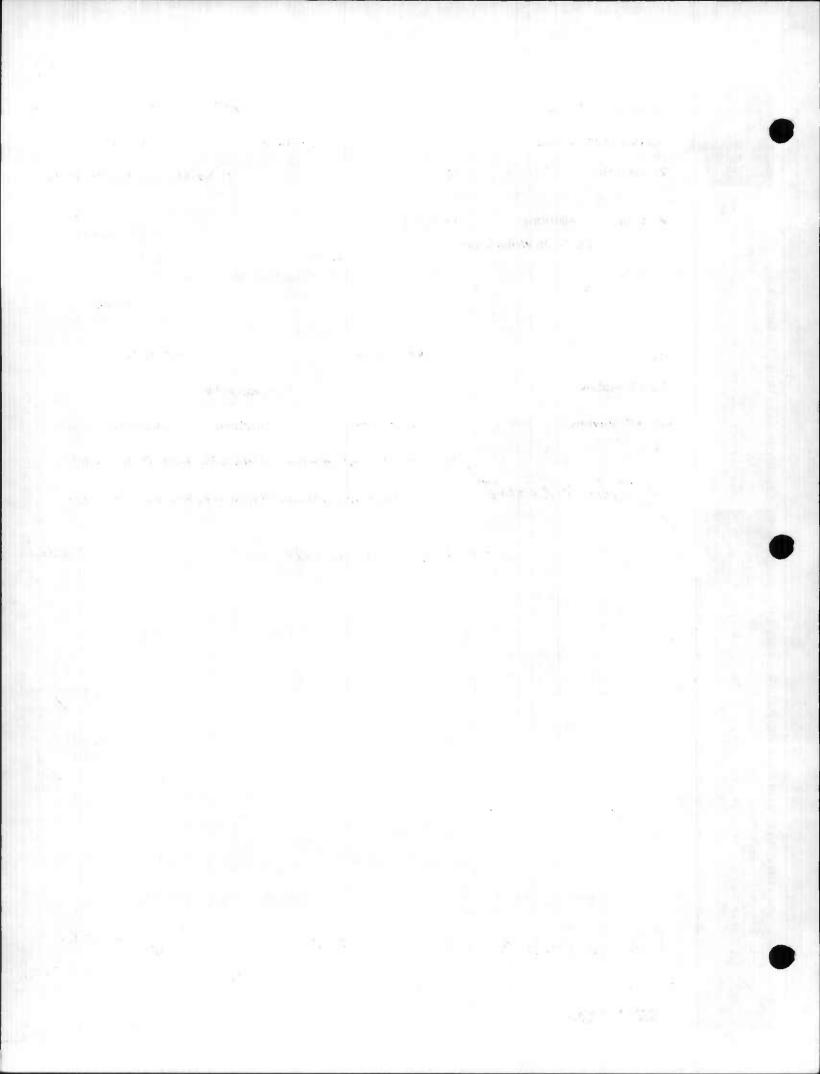
16,1998

Seton Drive Suk (cumberland Hd 21502

State Registrar 31. Dete tiled (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year RUTH SELF HELEN 1998 8:00 PM MAY 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth ALLEGANY CUMBERLAND CUMBERLAND NURSING HOME If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) 1□M 2₩F Deys Hours Vre 78 215-56-8669 DEC 14 1919 W.VA. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No MARYLAND FLINTSTONE ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21530 20610 FLINTSTONE CREEK ROAD 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ď No if Yes, Give Year or Dates: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American indian, Biack, White, etc. 1 Never Married 2X Married WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSE KEEPER HOUSE KEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MINNIE RAE IMES JAMES FRANK SOMERVILLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20610 FLINTSTONE CREEK ROAD FLINTSTONE MD. 21530 19a. Informant's Name/Reletionship (Type, Print) HUSBAND ALVIN SELF 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GLENDALE CEMETERY MAY 21 1998 4 ☐ Donation 5 ☐ Other (Specify) FLINTSTONE MARYLAND 21. Signature of Funeral Service License 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heert feilure. List only one cause on each line. Immediate Ceuse (Finel 6 weeks disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 | Yas 2 | No 3 | Probably W Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) MAY 18 1998

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

rel', or itsms 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours efter one of Heelth and Mental Hygiene.
Int: If them 27 is marked other than "natural", or its inty or other traumatic event, the Mental Easterner iny or other traumatic event, the Mental Easterner.

permit. Page Department of Important: If any Injury or

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The lew requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital Hospital or Attending Physician: 124 hours after death.
 Funersi Director: After this certifica Medical To the To the I MAS

State Registrar

31. Date filed (Month, Day, Year)

5 Pending Investigation

6 Could not be determined

1 ☐ Yes 2 🕡

27. Manner of Death

Naturel

2 Accident

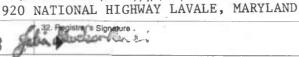
3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certific

DR VIK POONAI



30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

Hospitel: 1 ☐ Inpatient 21 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of injury - Albama, ferm, street, factory, office building, etc.

28b. Time of

28c. Injury et Work?

Medical Examinary on the basis of examination end/or Investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s)

29c. License number

Curtifying Physician: To the basis of examination and/or investigation in my calculate and due to the cause(s) and menner as stated.

| Medical Examination the basis of examination and/or investigation in my calculate and due to the cause(s) and menner as stated.

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28a. Date of Injury (Month, Day Year)

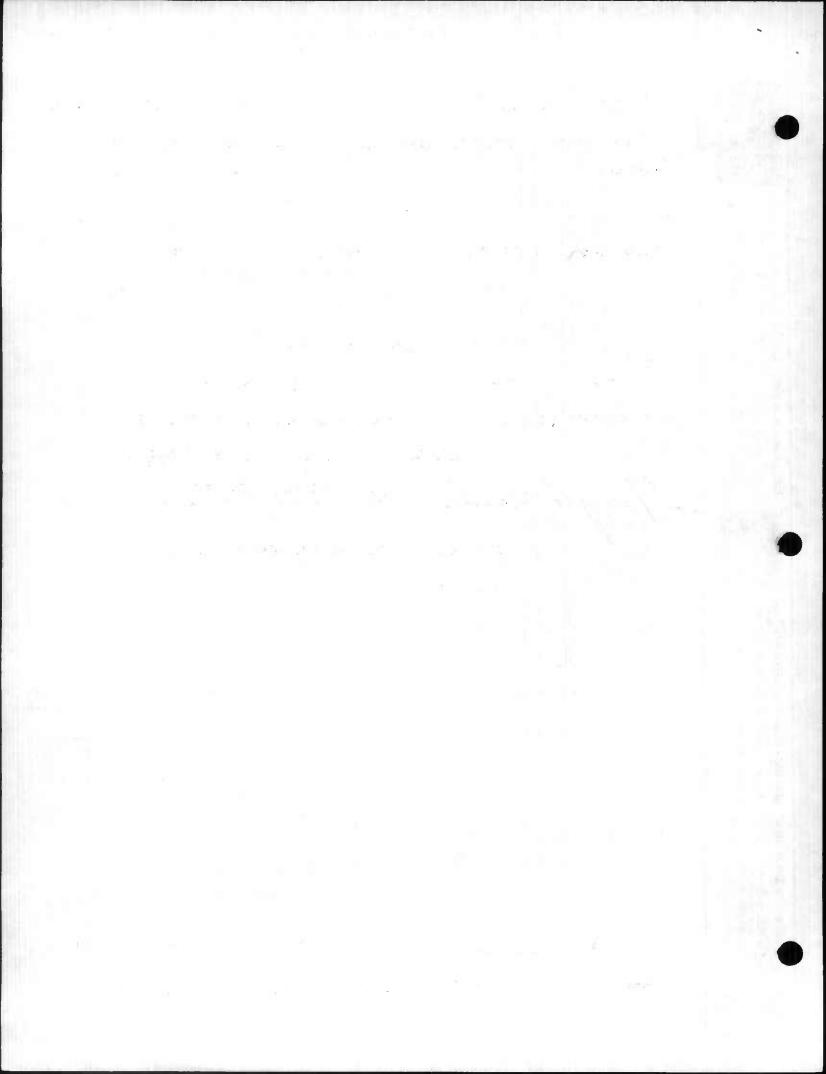
town to want

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tim f th **Physician** MAY 13, 1998 VESTER TAYBRON 6:53PM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 7. Age (In yrs. lest birthday) 85 yrs. 8. Date of Birth
(Month, Dey, Year)
2-20-1913 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country)
N.C. **Funeral** Months Deys Min. 1 XM 2 □ F Hours 578-03-0535 Director Usuel Residence of Decedant the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits D.C. WASHINGTON Director 1 X Yes 2 □ No r 28a-f s notified 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with ed other than "naturel", or items 23s or event, the Medical Examiner must be a 3019 CLINTON STREET N.E. 20002 USA Funeral 12. Wes Decedent Ever In U,S Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Merried Specify: BLACK Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) NIH College (1-4or 5+) BOILER ENGINEER 5TH permit, Pages 1 and 2 ahouid be file Department of Health and Mental Hy Important. If Nem 27 is marked othe any injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be THEODORIC TAYBRON 10 LIZA ADAMS 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) 3019 CLINTON ST.NE, WASH, DC. 20002 LUCY TAYBRON (WIFE) 20e. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Neme of 20c Location - City or Town, State SUITLAND Date cemetery, cremetory or other place)
LINCOLN MEM. CEM. 5-18-98 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND 22. Name end Addrass of Facility AUSTIN ROYSTER FUNERAL HOME 3821 14TH STREET N.W., WASH, DC. 20011 4cm or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each lina. Approximete Intervel Batween Onset and Deeth **Physician** Immedieta Ceusa (Finel diseese or condition resulting in daath) /Medical ARTERIOSCLEROTIC CARDIOVASCULIAL DISORDER Examiner Due to (or es a consequance of) Examiner PULMONARY The law requires that the deeth certificete be executed buriel-trensit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in daath) Last and Due to (or es e consequance of) Box 68760, physician Physician/Medicai the Due to (or es e consequence of): for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 8 24b. Wera autopsy findings evellable prior to completion of cause of daath? should Completed 24a. Was an autopsy performed? 990 pege 2 certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Wes casa referred to medical axaminar? 26. Plece of Deeth (Chack only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No Certification: To 1 ☐ Inpetiant 2☐ ER/Outpetient 3☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Netural 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide pelli Hospital 29e. Cartifian Medicai 1 Certifying Physician: To tha best of my knowledga, daeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. completely (Check only one) 2 XMedical Examinar: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner steted. To the Within 2 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D15236 OME MAY 13, 1998 30. Name end eddrass of person who completed causa of death (Itam 23a) (Type, Print)

State Registrar

31. Deta filed (Month, Dey, Year) MAY 2 1 1998

CARL I. MARGOLIS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD. 20852 Registrer's Signeture Was Davidson



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Year **Physician** May 16, Judith F. Thornton 1998 12:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 42 Tindal Springs Court Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthdey) 6. Dete of Birth (Month, Dev. Yeer) **Funeral** Months Days 1□M 2፟MF Hours 55 Yrs. 10, 1942 New York Director 126-34-0591 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. Stete 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with 42 Tindal Springs Court 20879 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
nt: if Item 27 Is marked other than "natural", or Items 23. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritai Status ☐ Yes 2 ☑ No Yes, Give 1 □ Never Married 2 □ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☑ Divorced White Year or Dates Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4 Systems Analyst Computer Company 17 Fether's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Charles Kirsh Betty Stricks 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennifer B. Thornton-Daughter 42 Tindal Springs Court, Gaithersburg, MD 20879 or other t 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other pleceMay 17 1998 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State pemit. Page Department of Important: if any injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland ture of Funeral Sec 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ e lice Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00689 ease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, re. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician ADENOGARCINOMA OF LEFT LUNG /Medical Immediate Ceuse (Finai MONTHU disease or condition resulting in deeth) Examine Due to (or es e consequence of) Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ģ The law requires 24b. Were autopsy findinga available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed i certificate has b 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director Be 25. Was cese referred to medical exeminer? 26. Piece of Death (Check only one) Hospitai: Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27, Manner of Deeth 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es atated.

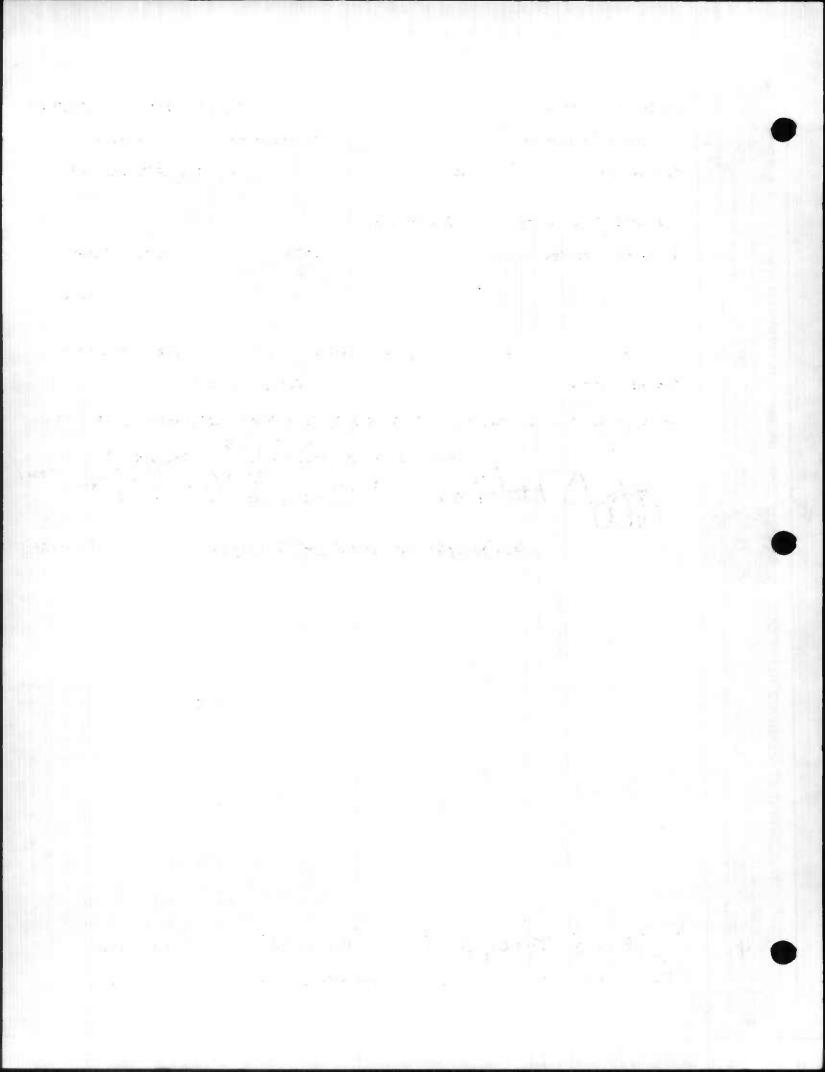
2 Medical Examinar: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Stoppature end title of certifier 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) May 17, 1998 James A. Brown, M.D. 9707 Medical Center Drive, #300, Rockville, MD 20850 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signeture State MAY 18

Irdia Savidson-Randall

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30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Wealitt MO

Lewis N. Cahill, M.D. 6000 Executive Boulevard, #300, Rockville, Maryland 20852
31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

29c. License number

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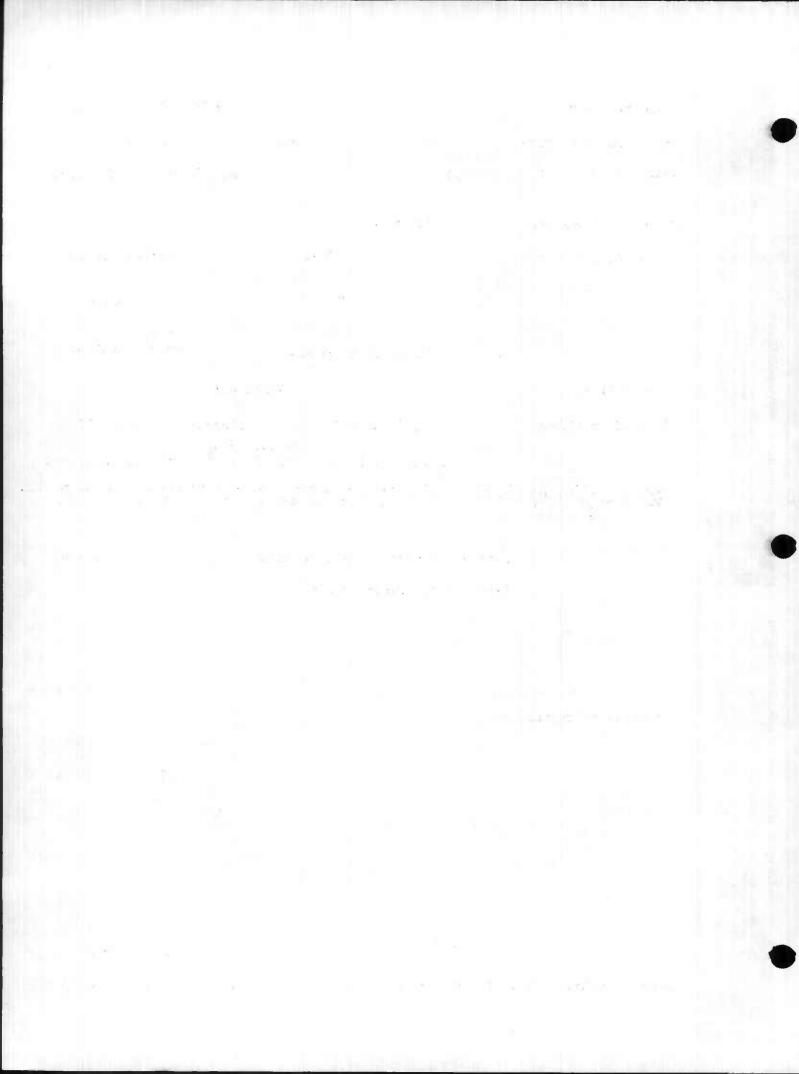
29d. Date signed (Month, Day, Year)

May 15, 1998

State Registrar MAY 1 8 1998

29b. Signature end title of certifier

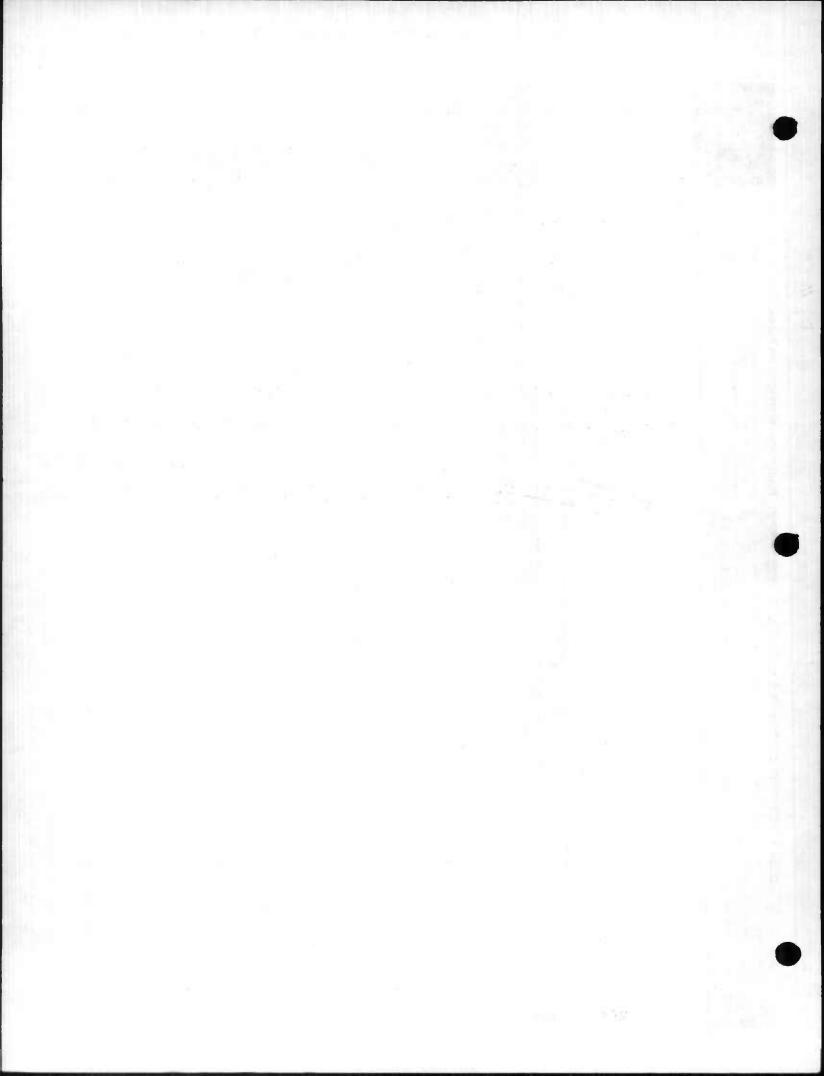




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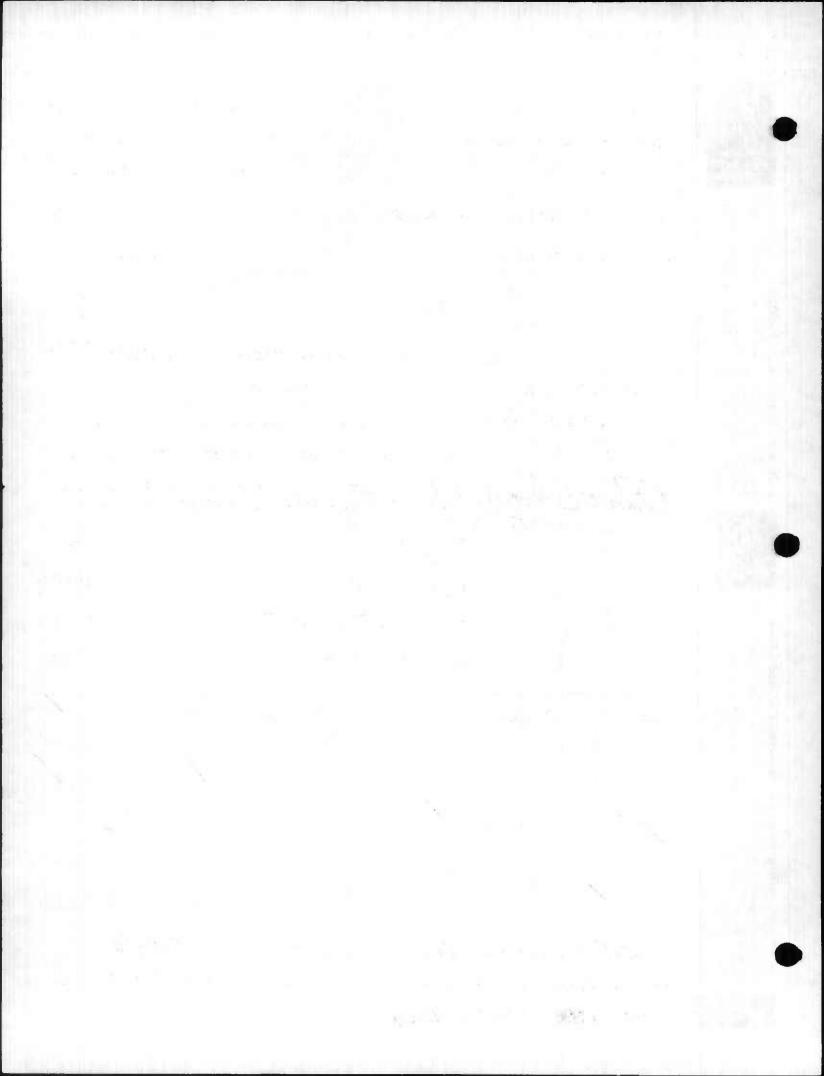
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	Physici /Medi		Elaine	Marie	Tay	lor					May		1998	7:00 1	P.M.
	Examir		4a. Facility Name (If not institu	tion, giva street end r	number)				4b. City, 7	Town, or Lo	ocation of Death	4c. County	of Death		
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П	Funerai		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Aga (In y			If Under 1 Y	aar If Unda	ar 24 Hrs. Min.	8. Date of Birti (Month, De)	h (. Year)		elace (Stete or I	Foreign
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Maryland 21215-0020	Men	P	Wayman W.	Taylor,	Sr.				Eve	elyn	Marie	Scofie	1d		
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Sal	Departiment Important In parties and		21. Signature of Funeral Servi	os Licensee		-	22.	Name end A	ddress of Fac	ility	wal Uam	0			
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	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	a. E	end s	Sta	SC	ren	al	dis	ease	,	i	5 7-00	245
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-	0 0 2	Physician/N	Part II. Other significant condi	Itlons contributing to	death but not r	esulting Ir	the unc	derlying caus	a given in Per	t I.	23b. Did t	obacco use co	ntribute to	the cause of	death?
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	w requiras thet been signed I should be det	by F	1190	1001001	10211	`									
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0	naral		27. Menner of Death 1 D Neturel 5 ☐ Pend	28e. Det	e of Injury onth, Day Year)	28b. T	Time of	28c.	Injury et Work?		28d. Describe h	ow injury occur	red		
<u>Ö</u>	Attending or death.	atic	2 ☐ Accident inve	stigation			4114	М	1 ☐ Yes 2	□No					
Division	or Att	Certification:	3 ☐ Sulcide 6 ☐ Coul 4 ☐ Homicide dete	rmined 200. Plac	ce of Injury - At Iding, etc. (Spe	home, fe	rm, stree	et, factory, of	fica		28f. Location (S City or Tow		er or Rura	/ Routa Numbe	er,
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	To the Hospital or Attending Physician: The is within 24 hours effect death. To the Funeral Director: Aftar this cardificate ha completely filled in by tha funaral director, paga	Med	one) 29b. Signatura and title certi	end ma	anner stated.			290.45	7 a number			29d. Date signe			-
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			30. Name and address of person		,					1 . 34	m. 1 1	21617			
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	Registr		MAY 2 2	-	Julia Da		- Pano	tell							



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate	of i	Death			Reg. No.	0	11100
	Dhark		1. Decedent's Name (First, Middle	, Last)							2. Dete of De		Year	3. Tima of Death
	Physic /Med		JOHN CHARL	ES VOTIPK	Ά							12, 199		8:40 A
	Exami		4a. Facility Name (If not institution FREDERICK MEMO					4		own, or Loc DERICI	ation of Deet K		y of Deeth REDER	
	Funeral Director		5. Social Security Number 506-62-5145	6. Sex 7.	Age (In yrs. last bir 51	thday) Yrs.	If Under 1 Months I	Yeer	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De AY 29,	1946	9. Birth Cou NEBR	place (State or Foreign ASKA
Т	p ,		Usual Residence of Decedent		40. 63. 7.		-0.						-	
	e Meryla	ctor	MD 10b. County FREDI	ERICK	10c. City, Tow ROS	EMON								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	19 90 S	Director	10e. Street and Number				10f. Zip C					10g. Citizen of		ntry?
	ath w		3623 PETERSVII			T		175				U.S		
020	72 hours after death with the Meryland natural", or Items 23a or 28a-f show ates! Examinet must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 TYes 2 If Yes, Give Year or Date	ss? □ No KOREA	1	Ves Deceder Yes, specify	Cuba	IIspanic Or an, Mexicar Specify:	n, Puerto R	olfy Yes or No lican, etc.)		ick, White,	can Indian, , etc. ITTE
2-0	72 hours natural',	ted	15. Decedent	's Education	VIETNAM 16a.	Deced	ent's Usual (Occup	ation	nt of use of in		16b. Kind of E	Business/In	idustry
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, Maryland	d 2 a s		19a, Informant's Name/Ralationsl VIVIAN H. VOT									LE, MD.	o, Stata, Zij 217	
Baltimore,	permit. Pages 1 an Department of Heel Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Place of cemata. SMITH	f Dispos ry, cram SBUR	ition (Name atory or othe RG CRE	of or place MAT	ORY	5/	Dete 13/98	20c. Location SMITHS		
x 68760,	Physician Medical Examiner physician and physician and physician and physician are seen the principle francia.	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last	a. b. c.	Due to (or as a PANCA Due to (or as a C Due to (or as a C Due to (or as a C DIRGET	Consequence Conseq	uence of):	pm	spla spla			rrest,		Approximete Interval Batween Onset and Death Shv 4 18 08 4 18 08 4 18 08
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la	ician: The L certificate he rector, page	ဝင္	25. Was case referred to medical						00 81-			Yes 2□No	1	☐ Yes 2M/No
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on of	ing Ph. After thi funeral	tlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of I (Month,	njury 28b.	Time of njury		Injur Wor		21		how injury occu		"
Division	if or Attending after death. Director: After d in by the fune	27. Manny of Death 1								21		(Street and Num wn, State)	ber or Rur	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledga, daeth occurred at tha time, data and piace, and dua to the cause(s) and manner as 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, date and piace, and due and manner stated.									statad. to the cause(s)		
	To the To the compl	Me										Oay, Year)		
			30. Name and address of person v		of death (item 23a)	(Type, F	Print)	d	117	10	EDMI	V MI	1 6	1707
			31. Date filed (Month, Day, Year)	1N 201	strads Signature	Jon	NOW	U	rejue	, 1/2	SINGUL	F- 110	2	
	Sta Regist	- 10	AY 1 4 199	8 Jahre	water Park	4								

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John J. Wurdack 11:28 AM WH) 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) April 28,1921 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours XXM 2 F Yrs. 175-12-3533 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland Beltsville 1 ☐ Yes 20No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4400 Samar Street 20705 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married XYes 2 □ No ITYes, Give Year or Dates: WWII 1 ☐ Yes 2XXXVo Specify Specify: White 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) 12 4 +4 Botanist Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John H. Wurdack Mary E. McMahon 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth J. Wurdack (son) same as #10 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata XX Buriel 2 Cramation 3 Removal from Stete Zions Stone Church Cem. 5/20/1998 NorthHampton, Penn. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YEAR Dua to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown HEART FAILLIRE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medicai Examiner

Physician

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Pages 1 and 2 should be next of Health and Mental

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of Health Item 27 is

Department of Important: If It any Injury or o

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bunal-transit the 80 USB for page 2 funeral director.

The law requires that the death certificate be executed

Box 68760.

P.0.

Records,

Division of Vital Attending Physician:

death.

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filled in

Medical

Examiner and physician signed by the a this After To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A the

Completed by Physician/Medical Be

State Registrar

Sequentielly list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending Invastigation 1 DNatural 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

> (Check only one) reland title of certifier bel

28b. Time of

29c. License number

28c. Injury at Work?

1 Cordifying Physician: To he best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

1 TYes 2 TNo

miner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENWAY CENTER MD

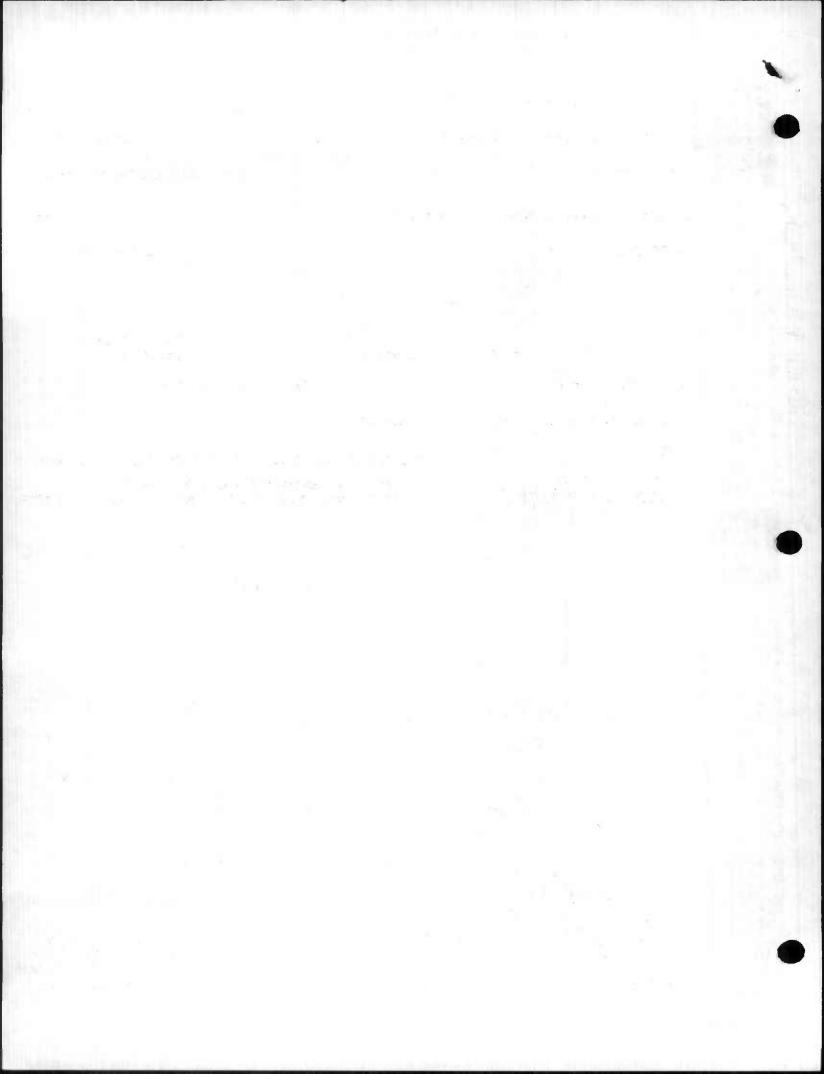
31. Dete filed (Month, Day, Year)

29a. Certifie

29b. Signal

MAY 1 9 1998

32. Registrar's Signature Ashia Davidson



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month WEAVER RTCHARD 1000 4b. City, Town, or Location of Beeth 4a Facility Name (If not institution, give street and number) 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Ris. 8. Date of Birth Months, Davs Hours Min. (Month, Day, Year) MONTGOMERY Birthplace (State or Foreign Country) Social Security Number Sex 1 AM 2 F Yrs. 133-01-6105 88 SEPT. 28, 1909 NEW YORK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NYes 2□ No BERKSHIRE GREAT BARRINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 95 WEST AVENUE 01230 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Raca - Americen Indian, Black, White, etc. 11. Meritel Stetus Yes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married Specify: WHITE 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grade completed) 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) PUBLICIST THEATRE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JACOB** WEAVER REBECCA **AVRAHAM** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MILDRED WEAVER-WIFE 95 WEST AVENUE-GREAT BARRINGTON, MASS. 01230 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-19-98 ALEXANDRIA, VIRGINIA MT. COMFORT CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 ove Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Que to (or es a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24e. Was an eutopsy performed?

Physician /Medical **Examiner**

injury or

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Physician

/Medical

Examiner

10a. State

MASS.

Directo

Funeral

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Funeral

Director

permit. Pages 1 end 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Marked Experiment must be notified as

Physician/Medical Examiner the attending physician and hed for use as the bunal-transit

signed by à Be Completed peen I Hes /98 / cartificata To this 5 Certification:

The law requires that the death certificate be axecuted P.O. Box 68760, Division of Vital Records, Hospital or Attending Physicien: Aftar ! within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun CLEARED BY ME

> State Registrar

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2□ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Inpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

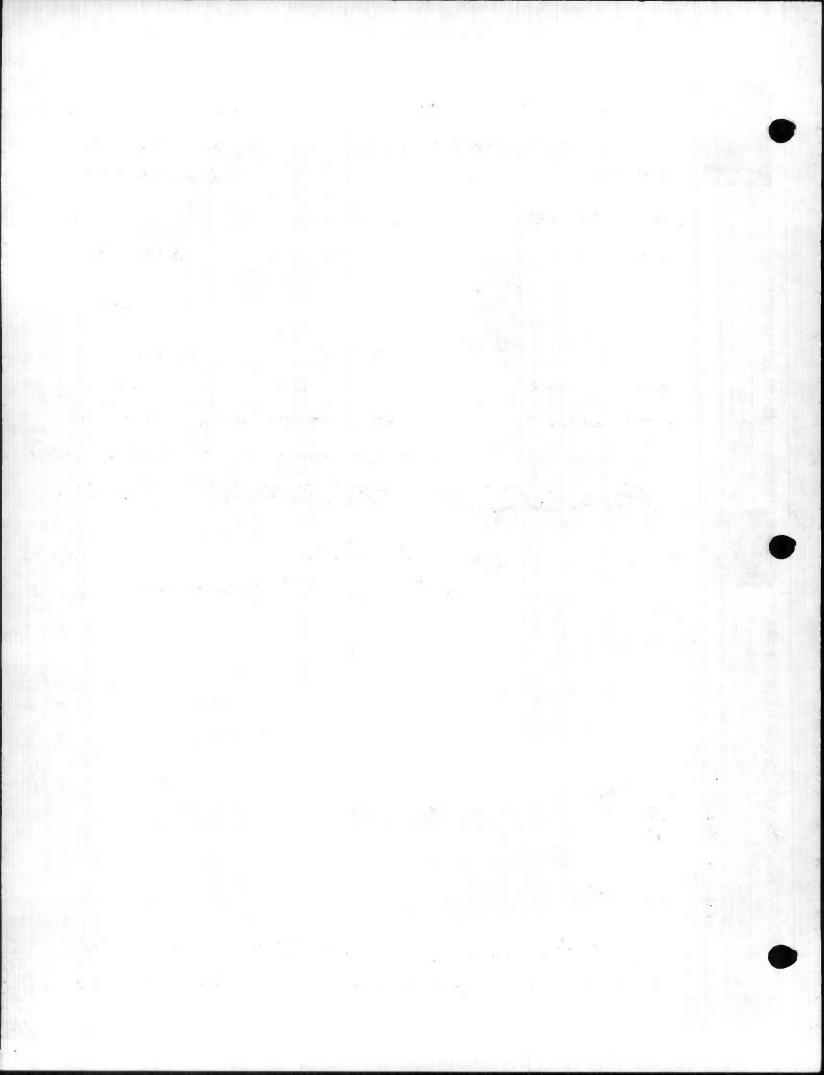
30. Name and addgess of person who completed cause of death (Item 23a) (Type, Print)

On

31. Date filed (Month, Day, Year) 1 9 1998 MAY

Registrar's Signature Solia Davidson

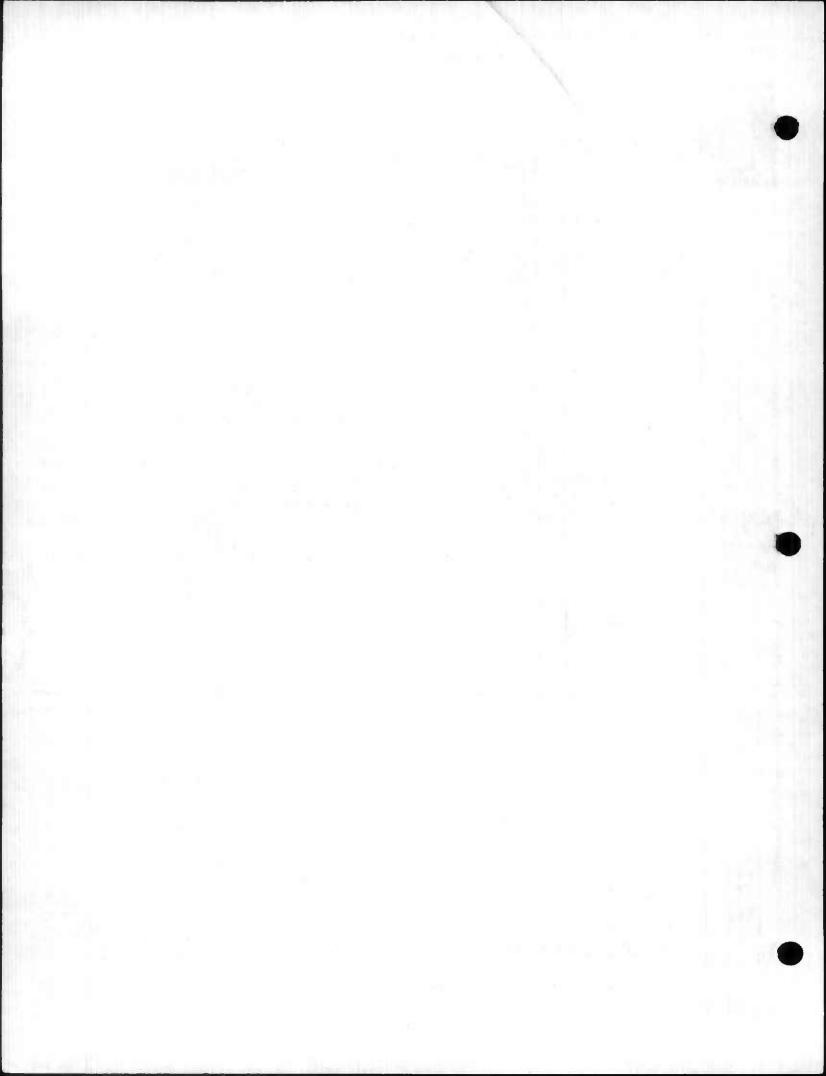
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State of Maryland / Department of Health and Mental Hygiene 98

						Cei	rtificate	of l	Death			Reg. No.		
	Physic	ian	1. Decedent's Name (First, Middle,		. 11 14	110					2. Dete of Di Month	eath Day	Year	3. Time of Death
	/Medi	cal	4- 5-95 Maria (# 4 4 4 4 4 4 4 -	Mary		ells					May 15			1:25 PM
7	Exami	ner	4e. Facility Name (If not institution, Holy Cross Hosp		m <i>ber)</i>				silve		ocation of Dea ring		ty of Death	
	Funeral Director		5. Social Security Number 246-36-5291	5. Sex 1 □ M 2 💢 F	7. Age (In yrs. le 73	st birthdey) Yrs.	If Under 1 Months D	Year Days	If Under Hours	24 Hrs. Min.	8. Dete of BI (Month, D Feb. 2	au Voor	9. Birth Cou Nort	place (State or Fore intry) h Carolin
	land land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Lim
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	# 2 ×	Dire	10e. Street end Number				10f. Zip Co					10g. Citizen of	What Cou	intry?
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50	72 hours effer deeth with the Maryland natural', or flerns 23a or 28a-f ehow iscal Examiner must be notified at	y Funeral Director	11. Maritel Stetus 1 Never Married 2 Marrie	Armed Fo	2 X No	1	Was Deceden If Yes, specify 1 ☐ Yes 2 ②	Cuba	spanic Ori n, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		ack, White	
00	uralf.	d by	3 🛱 Widowed 4 □ Divorced	Year or D			·						WILL	
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Maryland	should be filed with nd Mentel Hygiene. marked other than	To Be	Edward Eugene	Hunter,	, Sr.				Non	a E	obbins			
	and 2 shealth and 127 le m		19a. Informant's Name/Relationship Edward E. Hunter		(nephew)							d Park,	110	66213
ore	Peges 1 and 2 nent of Health a int: If Item 27 Is		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□ Removel from	0.0	ace of Dispo m <i>etery, cr</i> en	sition (Name matory or othe	of r plac	9)		Date	20c. Location	- City or T	own, State
Baltimore,	Peg Iment tant:		4 ☐ Donation 5 ☐ Other (Spe	cify)			ke Crei			5	-16-98	Beltsv	ille,	Maryland
Bal	permit. Departr Importu any Inji		21. Signeture of Funeral Service Lie	censee R	مم						ces, P.	A. Spring,	MD 20	0910
			23a. Pert1. Enter the disease, or co shock, or heart failure. List or	omplications that colving one cause on e	aused the deeth.								110 20	Approximate Interval Between
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1	/Medical Examiner		fmmediate Cause (Final disease or condition resulting in death)	a	6	2 gost	ne he	and	Jai	lun	e			1 week
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oʻ	e exectian and	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or	as a conseq	uen <i>ce</i> ot):						 	
68760,	eath certificete be executed attending physician and for use es the burlel-transit	edical	Cause (Disease or Injury that Initiated events resulting In death) Last	C	Due to (or	as a conseq	uence of):							
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	the at thed fo	Physician	Part II. Other eignificant conditions	contributing to de	eath but not resul	ting in the u	nderlying caus	e give	n in Part I		23b. Did	tobacco uee c	ontribute 1	to the cause of deal
P.0	2 20										1 🗆	Yee 2□ No	3 ☐ Pro	bably 4 Unkno
sp.	uires the	d by									24a. Was	s an autopsy	24b. W	/ere autopsy finding
Records,	w require s been si should	Completed										ormed?	0	vailable prior to ompletion of cause f death?
Re	he law e hes age 2	omp									10	Yes 2 No		□Yes 2M No
of Vital		BeC	25. Was case referred to medical					-	26. Place	of Deat	h (Check only			
1	Physician: this certific	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2 E	R/Outpatien	t 3 DOA	Othe	AF.			idenca 8 🗆 O	ther (Speci	ify)
0 4	neral d		27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of	of Injury th, Day Year)	28b. Time of Injury	28c.	Injury				how Injury occu		
Division	or Attending Pheter death. Director: After the lin by the funeral	Certification:	2 \(\text{Accident} \) 3 \(\text{Suicide} \) 4 \(\text{Homloide} \) 4 \(\text{Homloide} \) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)										ber or Ru	ral Route Number,
Ö	tal or al Dire	Cer	TIOMICIO	Duildii	ilg, etc. (Specily)						Chy or 10	wn, State)		
	To the Hospital or within 24 hours effer To the Funeral Dirticompletely filled in	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the aminer: On the ba and mann	asis of examination	ledge, death on and/or inv	occurred at to restigation, in	ne tim	e, date an Inlon, dea	d placa, th occur	and due to the red at the time	cause(s) and n , date and place	nanner as , and due	stated. to the cause(s)
	To the To the complex	M	29b. Signature end title of cartifier	, 1			29c. L	icense	number			29d. Date sign		, Day, Year)
1			Cahaay Al	emm			D	13	496			5-1	5 5	8.
\	'o		30. Name and address of person wh	o completed caus	e of death (Item	23a) (Type,	Print)			0		0	1	
			W attenmento W				angor	, (ous	94	4 502	Si'lng	spy.	ms 20910
	Sta Registi		31. Date filed (Month, Day, Year)	98 Ju	egistrar's Signatu	-Rande	ec_						•	

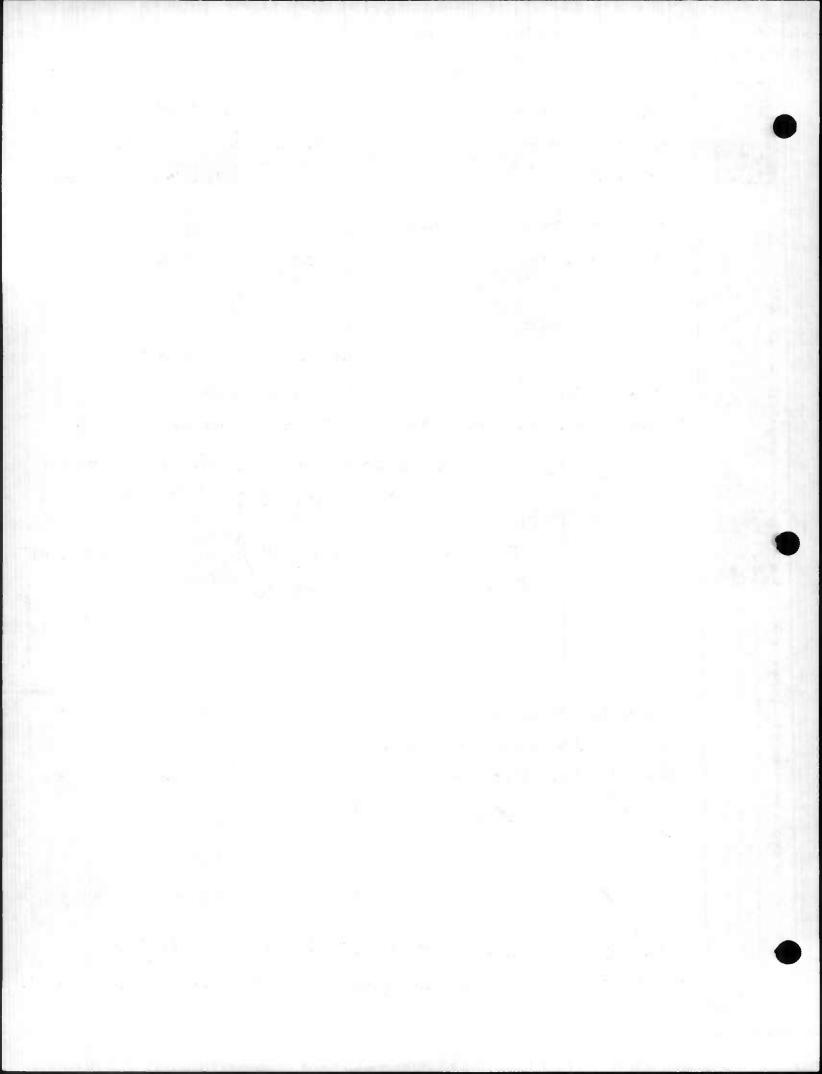
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					- Trial y lair a		tificate of	Death	F	Reg. No.	1 /	157
	Physic /Medi		Decedent's Name (First, Mic Margaret Ma						2. Date of Dee Month May 1.5	Day	Year	3. Time of Death 02:45am
	Exami		4a. Facility Name (If not Institut		iber)			4b. City, Town, or L		-	of Death	
			Holy Cross H	ospital				Silver S	pring	Mon	tgome	rv
П	Funeral		5. Social Security Number	6. Sex 1	7. Age (In yrs. lest		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birtl (Month, De)	h		ce (Stete or Foreign
4	Director		220-34-5526	1 M 2 M F	7.2	Yrs.						Kingdom
	pug A		Usual Residence of Decedent 10e. State 10b. Cour	itv	10c, City, To	own or Loc	eation				10	d. inside City Limits
	the Marylar 28a-f ehow coursed	ö	V1 1 1	,							100	1 ☐ Yes 2 ☑ No
		Director	Maryland Moni	gomery	Kensi	ngton	10f. Zip Code		1 .	10g. Citizen of	Mhat Countr	
	23a or			1 -			101. Elp 0000			77.1.7	Wilet Couliti	y r
	ter death with Items 23a or over malst be	Funeral	10835 Littlefo	12. Was Deced	dent Ever in U,S.	13. W	/as Decedent of I	20895 Hispenic Origin? (Spean, Mexican, Puerto	pecify Yes or No-	USA 14. Bac	a - America	n Indian.
21215-0020	E 6 m	by	1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divorc	If Yes Give	2 St No		Yes, specify Cub ☐ Yes 2 ☑ No		Rican, etc.)	Specif		ite
5-0	2 2 2	Completed	15. Deced	ent's Education nest grede completed)	10	6a. Decade	ent's Usual Occup	pation	kina	16b. Kind of B		
121		npie	Elementary/Secondary (0-12		4or 5+)	life. D	O NOT use retire	during most of world)	KHIY			
		ပိ		2	T	ravel	Supervi			Federal		rnment
and	be fill H d out	Be	17. Father's Name (First, Middl	e, Last)				18. Mother's Nan	ne (First, Middle,	Meiden Sumer	ne)	
N Z	should be filed ind Mental Hygi marked other umatic event, I	2		Burch					1 Burch			
Maryland	" = = =		19a. Informant's Name/Relatio					end Number or Ru				,
	s 1 and 2 should be filled I Heelith and Mental Hyg Item 27 Ia marked other other traumatic event,		William B. Whi	te, Jr. (son)	10835	Littlef	ord Lane	Kensin	gton, M		
O	nt of		1 ☐ Burial 2 【A Cremation		00000	etery, crem	etory or other ple	ce)	Dete	200. Eocation	City of 10w	n, State
Baltimore,	it. P.		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service		Metro		tan Cren		05/18/98	Alexan	dria,	Virginia
Ba	permit, Pages 1 and 2 Depertment of Heelth s Important: If item 27 is any injury or other tra once.		▶ M /	57//				Collins	Funeral	Home.	Inc.	
7	_		23a. Part1. Enter the disease,		used the death. D	500	O Univer	sity Blvd	I. W. ST	lver Sp	ring, N	
	Physician		shock, or heart failure. Li	st only one ceuse on ea	ch line.	o not ente	i tile illode or dyl	ng, such as cardiac	or respiratory an	est,	1	Approximate nterval Between Onset and Death
6	/Medical		Immediate Cause (Finel	Tec	منسو ما	C	-di-	was. The				he vear
	Examiner		disease or condition resulting in death)	a. 4-3	Due to (or as	a consequ	ence of):	901)414	7		1	ne year
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	tificate be executed g physician end as the buriel-transit	Examiner	Sequentially list conditions,	6. CO.	Due to (or as			01200				
90,	clan e	E I	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	J .							1	
68760,	sate t	edical	that initiated events resulting in death) Last	c	Due to (or es	a consequ	enca of):				!	
	ding p			d							1	
Вох	thet the death certificed by the attending properties as	Physician/N		<u> </u>								
Ö	the de	ysic	Part II. Other significant condi	tions contributing to dea	th but not resulting	g in the und	derlying cause gi	ven in Pert I.	23b. Did to	obecco use co	ntribute to t	he cause of death?
Is, P.0	S E 0	by	Diubetes	Mellita	5				1 🗆 Y	'es 2□ No	3 Proba	bly 4 Unknown
Records,	v require been si shouid t	leted	Peripheral	Vascula	- Dis	eu S	6		24a. Was a perfor	n eutopsy med?	com	autopsy findings able prior to pletion of cause
		Completed	Atrial 7	Fibrillete	ارن				1 🗆 Y	es 2 No	of de	
of Vital	ysiclan: Thi	Be	25. Was case referred to medic examiner?					26. Plece of Dea	th (Check only or	те)	1	
£	5 00	ဥ	1 ☐ Yas 2 No			Outpatient		4 LI Nursing H	ome 5 Resid			
no	Ing P	ion:	27. Manner of Death Naturel 5 ☐ Pend		injury 28t , Dey Year)	o. Time of injury	28c. Inju		28d. Describe h	ow injury occur	red	
Sic	Attending Physician: It death. sctor: After this certific by the funeral director,	cat	6 Accident inves	tigation				Yes 2 □ No				
Division	al or Attendi s after death. ii Director: A ed in by the fo	Certification:	4 Homicide deter	mined 200. Placa 0	of injury - At home, g, etc. (Specify)	farm, stree	et, factory, offica		28f. Location (S City or Town	treet end Numb n, Stete)	er or Hural F	Roufe Number,
	To the Hospital or Attending Phywitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the						curred at the time, dete end piece, end due to the cause(s) end manner ss stated. Igation, in my opinion, death occurred et the time, date and place, and due to the cause(s)				
	Vithin Vomp	Me	29b. Signature and title of certif				29c. Licans	se number	2	9d. Dete signe	d (Month, De	ey, Year)
			128 m	Drue	in 1	UD	DZ	5080		5/16/	99	
1	7		30. Name and eddress of perso	n who completed cause	of death (Item 23e	e) (Type, P	rint)			1001	(0	
			Frank N. 6	rayino, 1	0313 6	Seov	sia A	ve. Cil	ver So	rius. L	UD	20902
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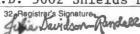
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iner	4a Facility Neme (If not institution, gr	ive streat and number,)			4b.	City, Town		ation of Deat		of Death	h			
	8100 Connecticut	Avenue #3	323				hevy				tgom	ery			
ıl r	577-22-2979	Sax 7. A	ge (In yrs. I		Months [Under 24 Hours	Min.	B. Data of Bir (Month, Di Oct. 3	th ay, Year) 1, 1900		nplace (State or Foraign untry) irginia			
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eg c	Samuel Irvin Wo								Houche		114)				
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	Dale L. Jernberg														
e l	20a. Mathod of Disposition	necorney	20b. P	Place of Dis	sposition (Nama	of			Data	20c. Location					
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Spec		Ce	dar F	Hill Cem	ar piacey	lay 2	2, 1	998	Suitlan	d M	aryland			
1	21. Signature of Funeral Service Vice						9	7							
	1011	. 1	M0019	98	/)) / W'	1 S C O 1	nsin	AVE	1116		Chas	se, Inc.			
		molications that cause			Bethes	21. Squature of Funaral Sarvice Ucensea M00198 R22.Name and Address of Facility R6bert A. Fumphrey Func 7557 Wisconsin Avenue Bethesda, Maryland 2									
	23a. Part1. Enter thi disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.											Approximata			
ian	shock, or heart failure. List only one cause on each line.											Approximata Intarval Batween Onsat and Death			
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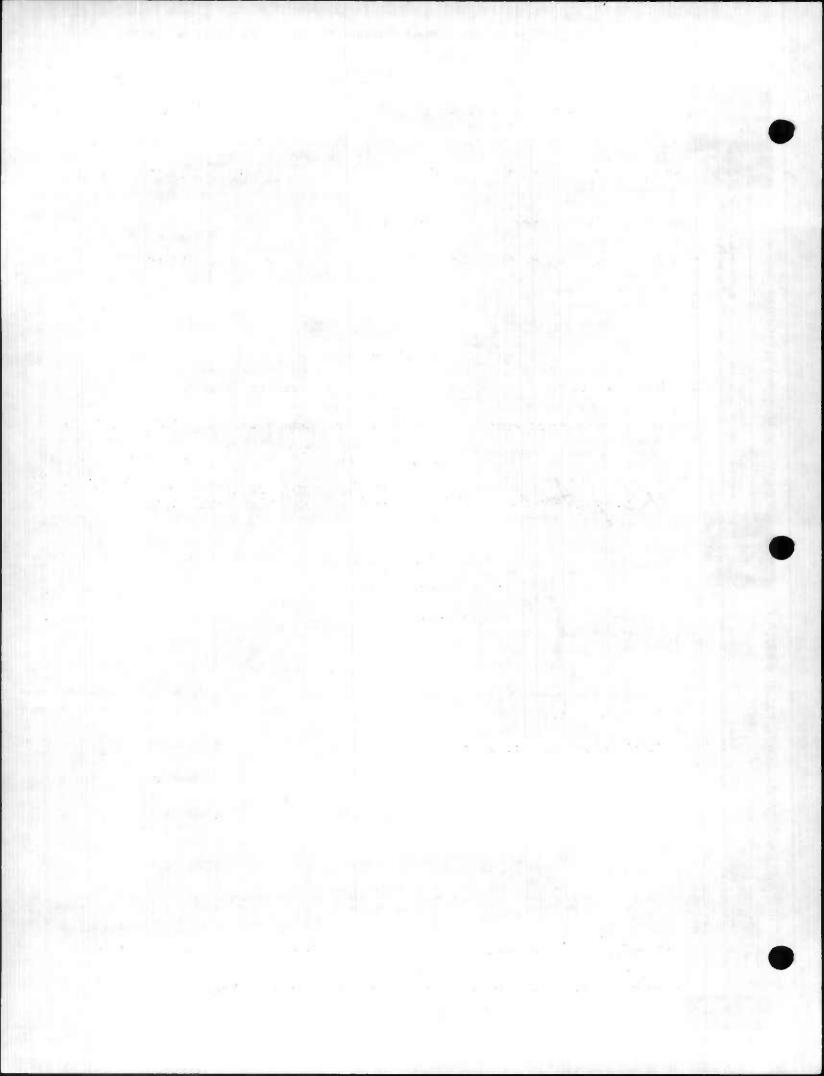
State Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

31. Data filed (Month, Day, Year) MAY 2 1 1998



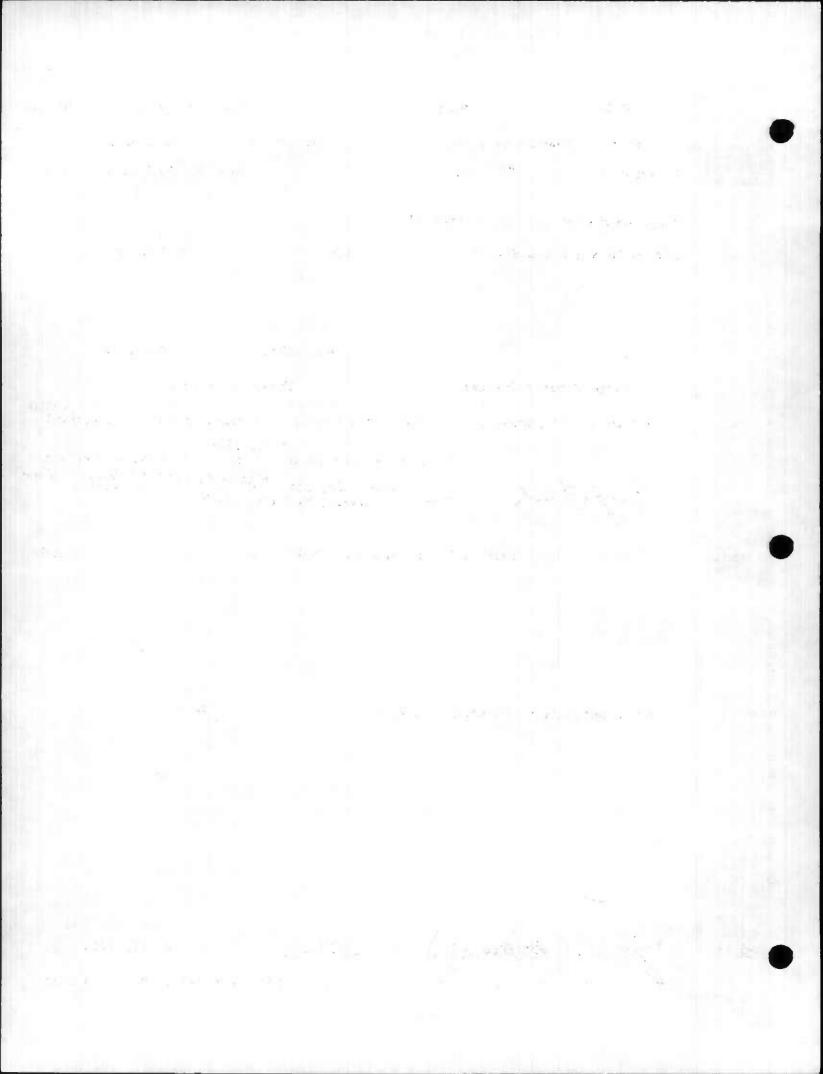


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Year **Physician** 6:30 A.M. Helen Jo Wilt May 17, 1998 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner 209 North Van Buren Street Rockville Montgomery If Under 1 Year 8. Dafe of Birth (Month, Dey, Year) July 31, 1 9. Birthplace (State or Foreign Country) Vest Virginia If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 □ M 2 1 F 1937 West 60 Director 235-56-0535 Usuai Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mod sal Examiner must be notified at 1X Yes 2 □ No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Streef and Number 10f. Zip Code with 20850 United States 209 North Van Buren Street Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Biack, White, etc. 12 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or har 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: Baltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced Yeer or Detes: Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Tacy Marie Fluharty George Fleming Weekley 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20850 19a. Informent's Name/Reletionship (Type, Print) permit. Pages 1 end 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum pncs. George E. Wilt/Husband 209 North Van Buren Street, Rockville, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) May 21, 1998 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremetion 3 ☐ Removei from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Avenue 21. Signature of Funeral Service Licensee Rockville, Inc. M00198 Rockville, Maryland 20850 0 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Small Cell Carcinoma of Right Lung 5 Months Examiner Due to (or es a consequence of): Examiner deeth certificate be axecuted attending physician end for use as the buriel-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): USB BS 23b. Did tobacco use contribute to the cause of death? Pert ii. Other algnificant conditiona contributing to death but not resulting in the underlying cause given in Pert i. P.O. 1K Yas 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease of Vital Records, ð 8 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? page 2 s certificate has 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 Yes 2 No 5 After this funeral 28a. Date of injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 27. Manner of Death 28c. injury at Work? Certification: al or Attanding Patter death. Division 5 Pending investigation 1 X Neturai 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Sulcide Place of injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29e. Certifier Medical completaly (Check only one) To the I 29d. Date signed (Month, Dey, Year) 29b Signaface and title of certifier 29c. License number 凝几 May 17, 1998 pluy id eddress of person who completed cause of deeth (item 23a) (Type, Print) 9707 Medical Center Drive, #300, Rockville, Maryland 20850 James Brown, M.D. 31. Date filed (Month, Day, Yeer) 32, Registrer's Signature State Julia Davidson-Randelle Registrar MAY 2 1 1998

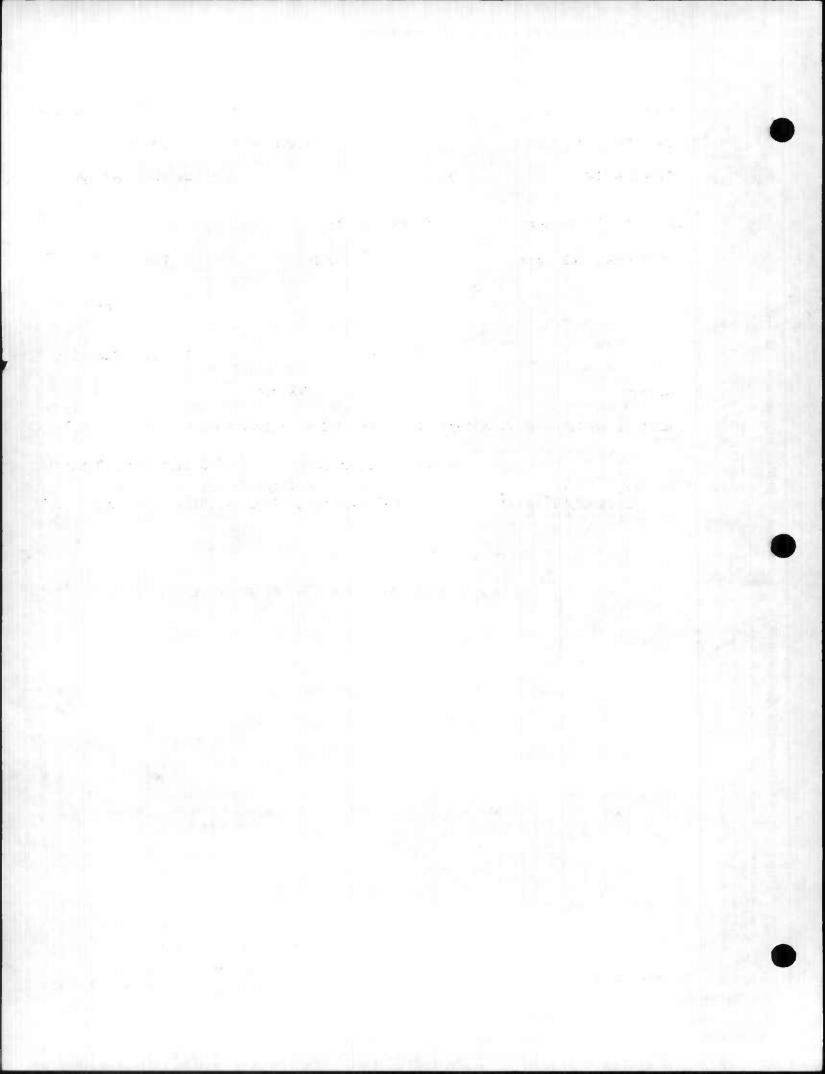
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middla, Last) Month 1998 May 15, 10:10PM Joseph K. Wivel 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death 10 Virginia Drive Gaithersburg Montgomery 8. Data of Birth (Month, Day, Year) July 25, 1 If Under 1 Yeer If Undar 24 Hrs. 5. Social Security Number 7. Age (In vrs. lest birthday) Birthpleca (State or Foreign Country) Deys Months Hours Min 1 M 2 □ F Yrs. 1947 Washington, DC 579-64-2962 50 Usual Residence of Decedent 10a Slala 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 10 Virginia Drive 20877 **IJSA** 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Bace - American Indian. 11. Maritel Slatus Bleck, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detes: 1 □ Nevar Married 2 □ Married 1 Yes 2 No Specify Specify White 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highest grede completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) General Contractor Construction 18. Mother's Neme (First, Middle, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) William B. Wivel Mary Ann Murphy 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) William F. Wivel (brother) 4888 Ridge Road, Chesapeake Beach, MD 20732 20e. Method of Disposition 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) Dete 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cramallon 3 ☐ Ramovei from Stete 4 ☐ Donation 5 ☐ Other (Specify) 5/19/98 Rockville, MD Parklawn Memorial Park 22. Name end Addrass of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signeture of Funerel Servica Licanses 20901 Silver Spring, MD 20901

23a. Parti. Entar the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Silver Spring, MD Approximete Intervel Betwaen Onsat end Deeth Immediata Cause (Final diseese or condition resulting in deeth) Glioblastoma Multiforme Due to (or es e consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Last Due to (or es e consequence of). Due to (or es e consequence of): 23b. Did tobacco usa contribute to the csuss of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Ysa 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings eveilable prior to complation of causa 24e. Wes en eutopsy 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitei: Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b Time of 28c. Injury et Work? 5 Pending Investigation 1 Neturei 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, streel, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) 29a. Certifier

Division of Vital Records, P.O. Box 68760.

law requires that the death certificate be axecuted certificata hes b The or Attending Physicien: his s after de. death.

Physician

/Medical

Examiner

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pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other treumstic event, the Medical Exercise must be not any energy.

Physician /Medical

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29b. Signature and title of certifier

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1998

Baltimore, Maryland 21215-0020

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State

Registrar **DHMH 16 Rav 6/95**

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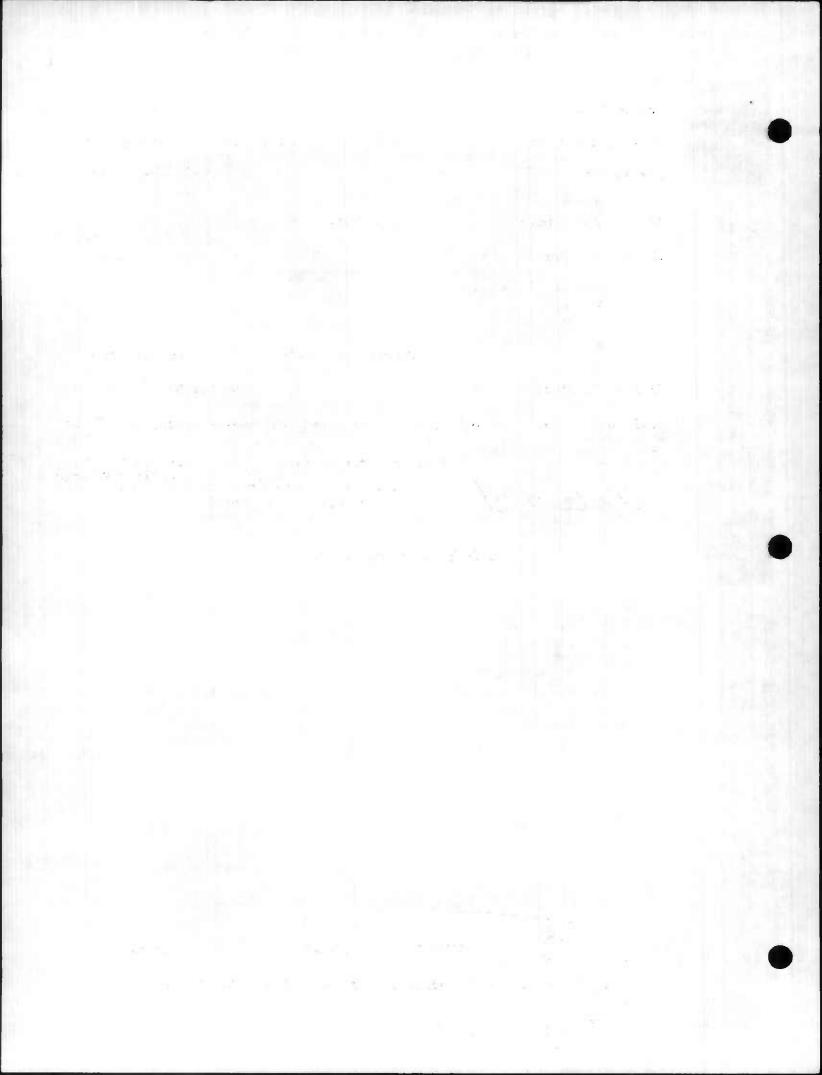
29c. License number D35370

29d. Dete signed (Month, Day, Year)

May 18, 1998

11125 Rockville Pike, Rockville, MD 20852

whice Davidson Mandelle



State of Maryland / Department of Health and Mental Hygiene

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			30. Neme end eddress of person who Dr. Brian M.	completed cause of deeth Conner M.	(Item 23e) (Type, Print) D. 501 W.	7th St.,Fr	ederick,	Md.	21701	
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registrer's S	igneture					

State Registrar MAY 1 9 1998

32. Registrer's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1 Decedent's Name (First, Middle, Last) Day 1998 THOMAS BROWN WAINWRIGHT May 15, 4b. City, Town, or Location of Deeth 4e Fecility Name (If not Institution, give street end number) 4c. County of Deeth Northampton Manor Nursing Home Frederick Frederick 7. Age (In yrs. last birthday) 80 Yrs. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dev. Year) Birthpiece (State or Foreign Country) ₩XM 2□ F Months Days Hours Min 214-10-1199 25, 1917 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. inside City Limits 10b. County Yes 2 No Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 612 Wilson Place 21702 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 (2x) Yes 2 □ No If Yes, Give Year or Dates: WWII Wes Decedent of Hispenic Orlgln? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritai Status 1 Never Merried 2 Married 1 Yes 2000 White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) 7 th College (1-4or 5+) Fuel Oil Business owner and operator 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Mary E. Lynch William L. Wainwright 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Grace Dixon Wainwright, wife 612 Wilson Place Frederick, Maryland 21702 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Olivet Cemetery 5/19/98 Frederick, Maryland 21. Signature of Funeral Service Lipengee 22. Name end Address of FacilityStauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 caused the leath. Do not enter the mode of dying, such as cerdiac or respiretory errest, each line. Approximate Interval Between Onset end Death Cell Concer of the Lung immediate Cause (Final disease or condition resulting in deeth) Squamous Due to (or es a consequence of) Sequentielly list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Yee 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

permit. Pages 1 end 2 should be filed within 7; Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Media page.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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Physician/Medical Examiner attending physician end for use as the bunel-transit 88 signed by the a þ been sig Completed certificate has b lirector, page 2 sl Be 10 this After this funeral Certification:

The law requires that the death certificate be executed

or Attending Physician:

the Hospital

death.

within 24 hours after death To the Funeral Director: A completely filled in by the f

Box 68760.

Division of Vital Records, P.O.

24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? 1 ☐ Yes

25. Wes case referrence exeminer?	red to medicel
1 Yes 2 ₺	No
1 105 24	140
27. Menner of Deetl	٦
1 Natural	5 Pending investigation
2 Accident	investigation
3 Sulcide	6 ☐ Could not be

1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 45 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

26. Piece of Death (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 ☐ Homicide

ttal Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as stated.

2 ☐ Medical Examinar: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number

29d. Dete signed (Month, Dey, Yeer)

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MD

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Frederick MO

21701

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

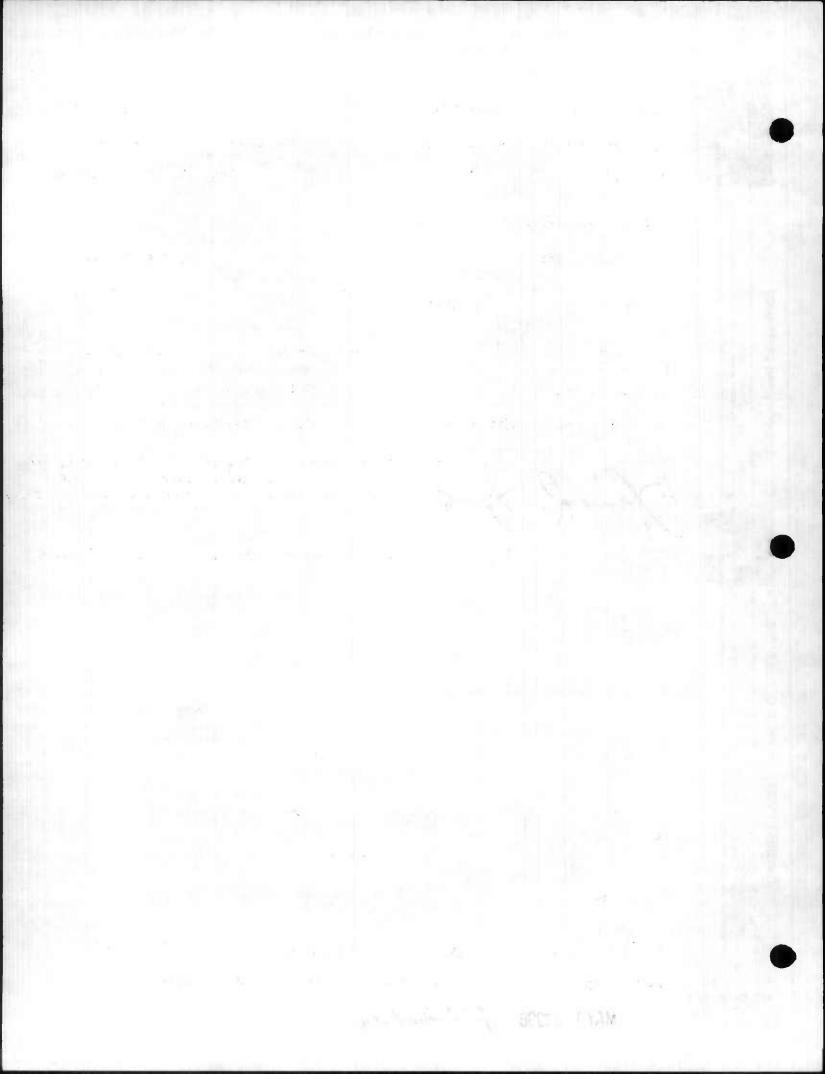
Suite 204 AUR

Taney 31. Dete filed (Month, Day, Year) 8 1998

32. Registrar's Signature whi Shudson Re

State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 15 1998 C. Webb, 8:30 AM John May /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not Institution, giva street and number) **Examiner** SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) MONTGOMERY 6. Sax 1 № M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days Yrs. 006-22-9665 70 March 6, 1928 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Directo Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23701 Eli Lane 20882 U.S.A. Funeral 12. Was Decedanf Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whifa, atc. 1X Yes 2 No If Yes, Give Year or Dates: 1952-54 1 Never Married 2 Married 1 Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Self Employed Cultural Engineer 6 18. Mother's Name (First, Middle, Melden Surname) 17. Father's Name (First, Middle, Last) Helen Hewitt John C. Webb, 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. informent's Name/Reletionship (Type, Print) 23701 Eli Lane, Gaithersburg, Maryland 20882 Diane B. Webb - Wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial Gardens 5/19/98 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si n ture of Funeral Service Licensee 22. Name and Address of Facility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 Villiams mert Inter the disease, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, r heert feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death immediate Cause (Final diseese or condition resulting in daath) gall bladder carcinoma Due to (or as a consequence of) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of). 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown mpoxia þ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Thromboytopenia 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) To Hospital: 1, Annatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1/Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29c. License number 0 46398

409,

29d. Date signed (Month, Day, Year)

ROCKVINE.

15, 1998

mp 20852

attending physician and for use as the burial-transit The law requires that the death certificete be executed P.O. Box 68760, Division of Vital Records, certificate hes b lirector, page 2 s funeral director, After this filled in by

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mental Hygiens. Important: If Item 27 Is marked other than "natural", or thems 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified at once.

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

24 hours efter death. To the Hosp within 24 hor To the Fune completely fi

> State Registrar

edical

29a. Certifiar

(Check only one)

29b. Signature and title of cartifier

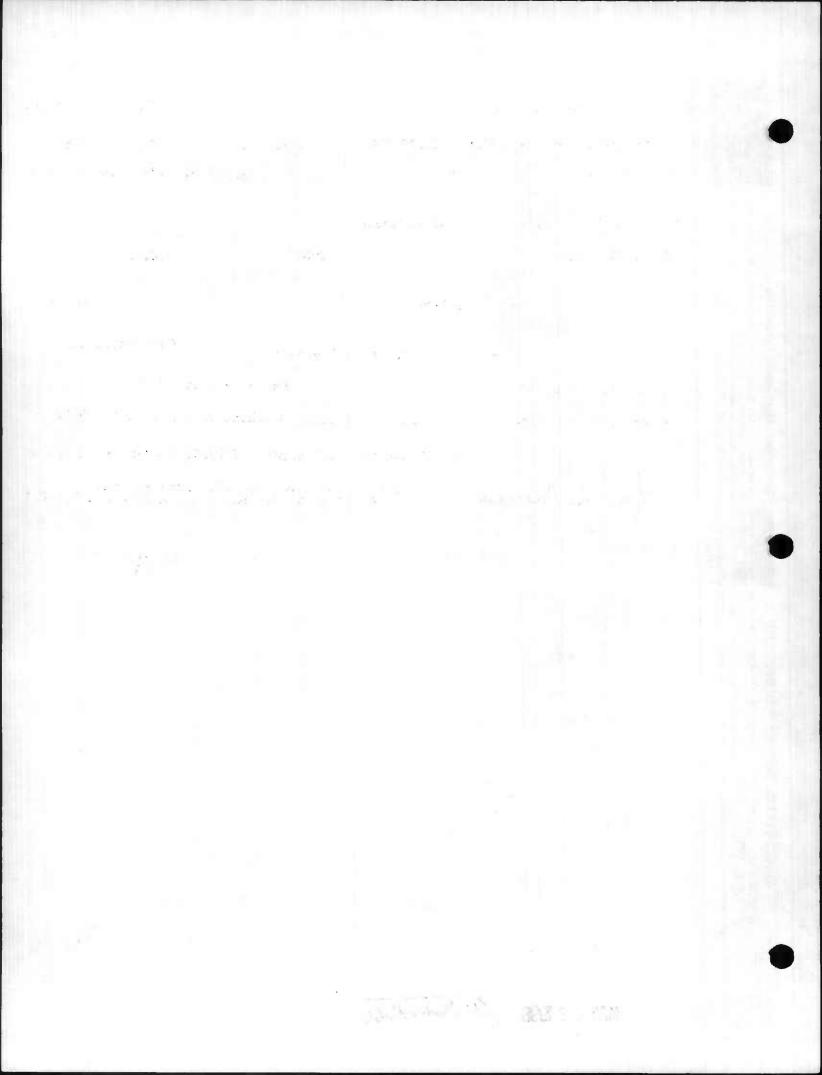
G. Gypta, mo

31. Date filed (Month, Day, Yeer) MAY 1 8 1998

Garyota, mo

121 congressional

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)



signed by the a d be detached f Completed is certificate has I director, page 2 Be Certification: To this funeral After s effer dec.

24b. Were sutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed?

25. Wes case referred to medicel examiner? 1 Yes 25 No 27. Menner of Death 1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation

28a. Date of fnjury (Month, Day Year) 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Plece of Deeth (Check only one)

1 ☐ Yes 2 🗙 No

1 Certifying Physicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Dete signed (Month, Day, Year)

1 Type 2 No

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

2 6 1998

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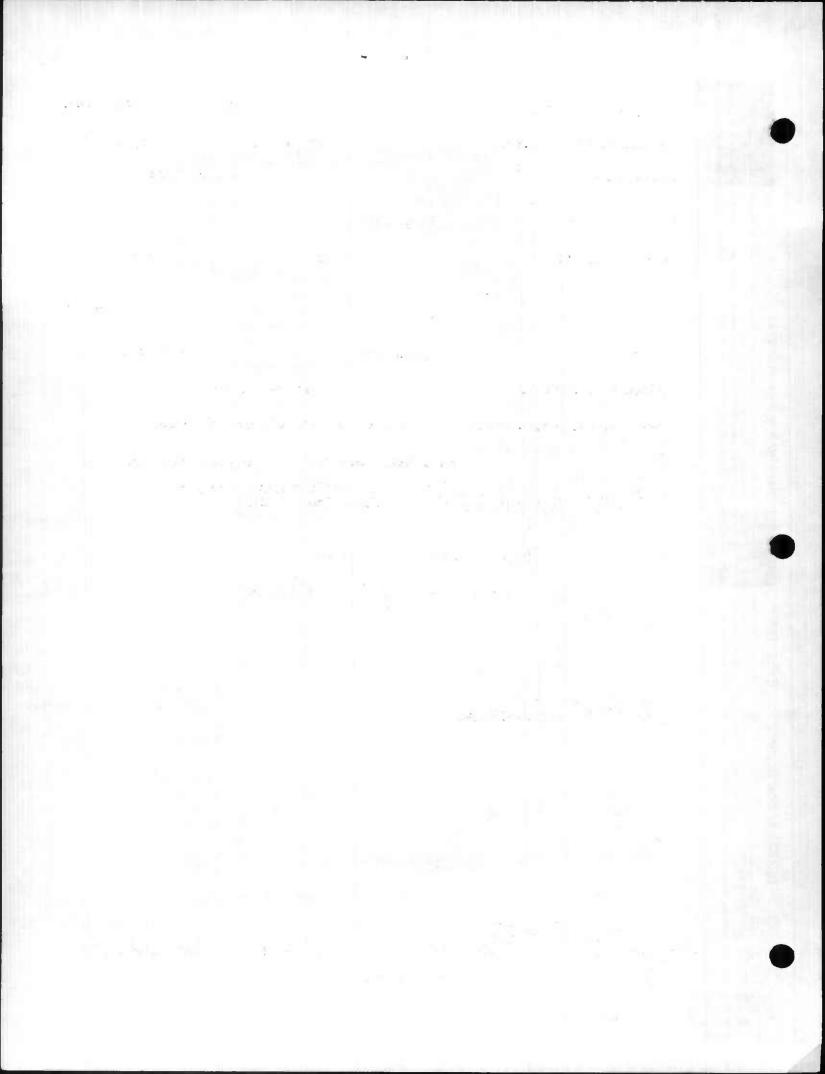
Registrar

Medicai

32. Registrar's Signature

Hospital or Attanding Physician:

To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Data of Death Month **Physician** Yaar 18, 1998 Julia 6:55 AM WITTIG May /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Homewood Retirement Center Frederick Frederick If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yaar) if Undar 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□M 2XF Months Days 97 Yrs. 081-09-9020 Director DOC, 19, 1900 FTaly Usual Rasidence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Haaith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations in the notified as Frederick Fredorick 1 Yas 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA Fieldcrost Dr. 21701 Funeral 12. Wes Decedant Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 ☐ Yas 2 No If Yas, Give Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 25 No by white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Designer Fashion FashiON 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Frank Ferrucci Vosephine Marie Puglie

19e. Informent's Name/Ralationship (Type, Print) G-rand SON 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64601 William A. Schuettenberg Country Club Dr, Chillicothe, Mo.
ition (Nama of Data 20c, Location - City or Town, State 2216 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) May Rosthaupu Evenatory 19,1998 Frederick, Md. 21. Signatura of Funaral Service Licensaa Leasure-Stein Funeral Home 230 Baltimore Ave, cumbonload, Md. 21502 23e. Part 1. Entar tha disease, or complications thet caused tha death. Do not antar the mode of dying, such es cardiec or respiretory arrest, shock, or haart failura. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting In deeth) /Medical 10 Yrs. Congestive Heart Failure Examiner Dua to (or as a consequence of): attanding physician and for use es the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in daath) Last Due to (or as e consequance of) Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es a consaquance of): signed by the atta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Squamous cell carcinoma of oral cavity þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen Alzheimers disease has 1 Yas WNo After this certificata 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was casa referred to medical axaminar? Be 26. Place of Deeth (Check only ona) Hospitel: Othar: 4 M Nursing Homa 5 Pasidence 6 Othar (Specify) 1 Yas ⊅OXNo Certification: To 1 Inpatient 2 ER/Outpatiant 3 DOA 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 ☐ Yas 2 ☐ No To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Al 2 Accidant 6 ☐ Could not be datarmined 3 Sulcida 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) in by 4 Homicida XX Certifying Physician: To the best of my knowledge, deeth occurred at the time, data end place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Certifier Medical

29c. License number

D 351 83

29d. Date signed (Month, Day, Year)

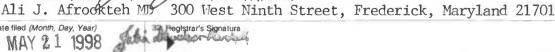
May 18, 1998

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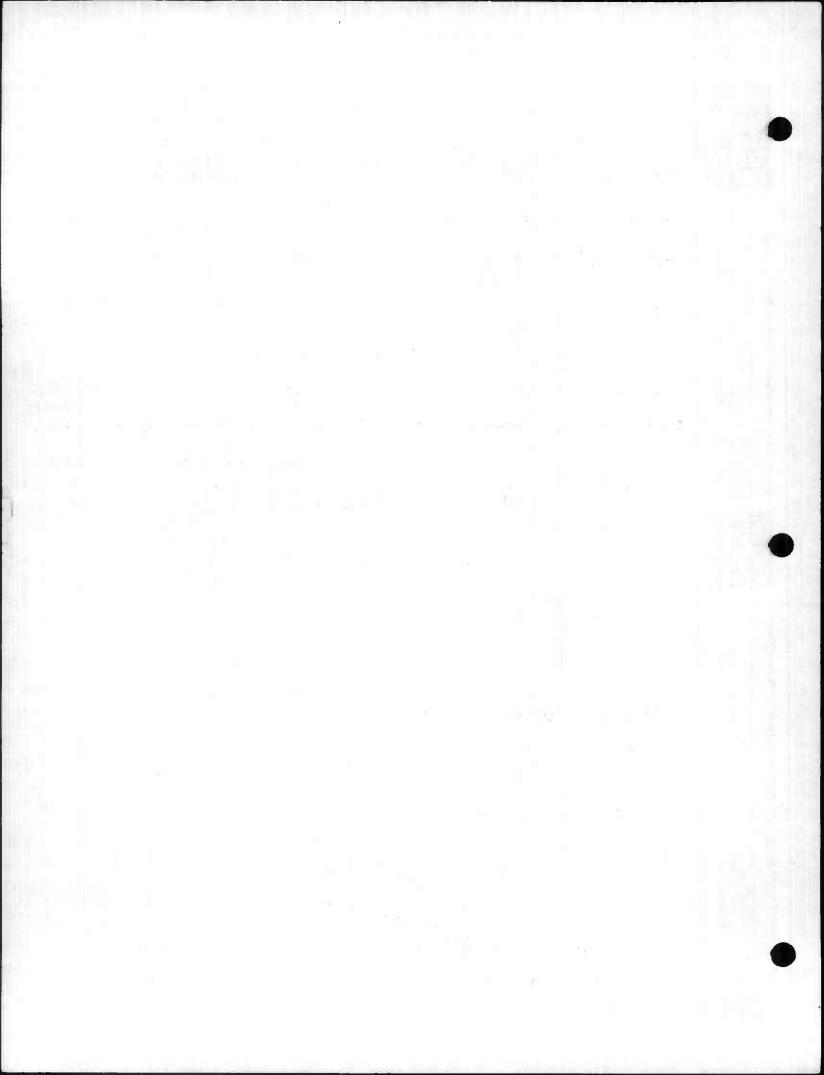
> 31. Date filed (Month, Day, Year) MAY 21 1998 Registrar

29b. Signatura and title of continue

30. Name and eddrass of person who



complated sause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17^{Day} Month MAY **Physician** CHI PYONG YIIN 1998 10:13PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mariner Nursing Home Wheaton Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min. Yrs. 81 Sept. 29 Director 1916 Korea 467-53-1737 Usual Residence of Decedent with the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar main to notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12001 New Hampshire 20904 Korea Funeral death 12. Was Decadent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours affert Department of Haaith and Mental Hygiene. Important: If flem 27 is marked other than "natural", or fler any injury or other traumatic average. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify: λq Asian 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Employee Korean Government 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Hi Yun Sang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yoon Soo Jung 12001 New Hampshire Ave., Silver Spring, Md. 20904 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X gurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-22-98 Olney, Maryland Norbeck Memorial Park 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire, Ave., Silver Spring, Maryland 20904 Aller ant. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final STROKE HOURS disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner Pneumonia requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Pseudomonas Infection Physician/Medicai the Due to (or as a consequenca of): 65 Decubitus Ulcer use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? P.0. the signed by the 1 ☐ Yes Z☐No 3 ☐ Probably 4 ☐ Unknown À 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peeu has page 2 2X No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Division of Vital Records. certificata Attending Physician: funeral director. this

After al or Attending after death. Director: Aft 24 hours a Hospital

J.

Certification:

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18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

D21033

28c. Injury at Work?

1 Yes

2 No

29d. Date signed (Month, Day, Year) May 18, 1998

28f. Location (Street and Number or Rural Route Number, City or Town, State)

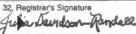
Other: Nursing Home 5 Residenca 8 Other (Specify)

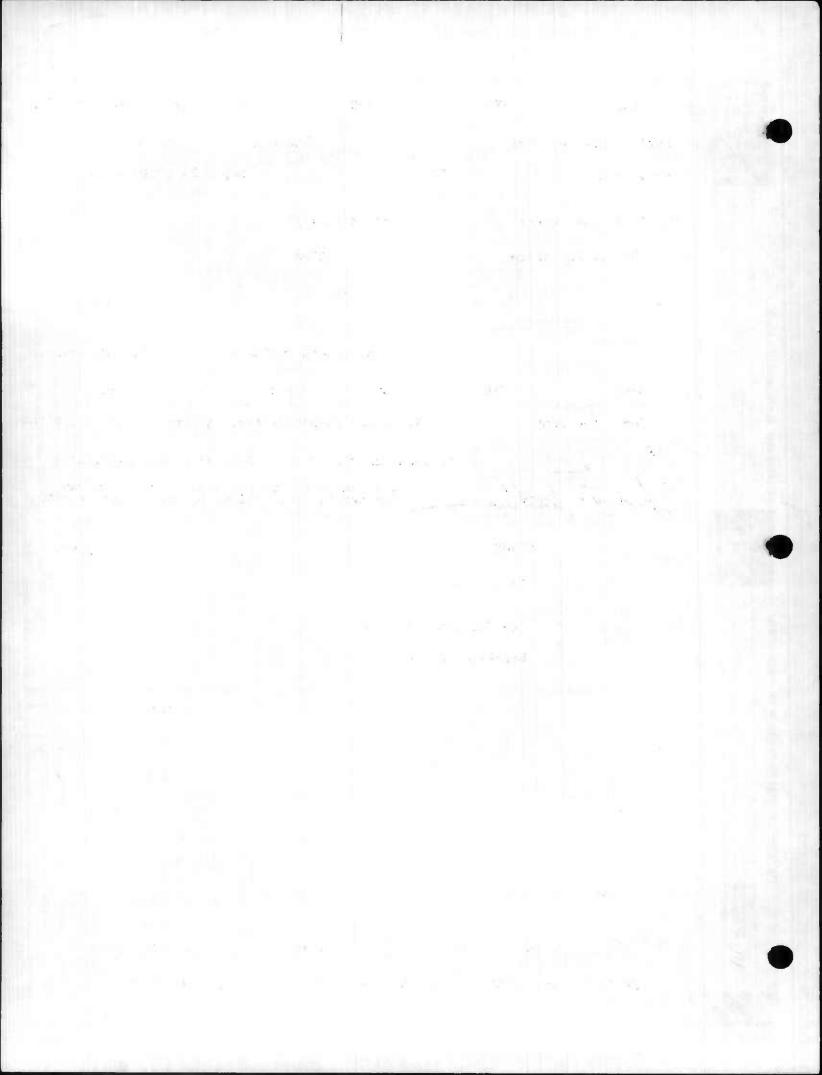
28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Byoung K. Lee, 13000 Georgia Ave., Silver Spring, Maryland

State Registrar 31. Date filed (Month, Day, Year) MAY 2 1 1998





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month WILLIAM JACOR ZERWICK 1550 MAY 1998 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MIOLAND DOAD SILVER SPRING MONTGOMER Months Days Hours Min. Augus 5, 1912 6. Sex 1 ☐ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiace (State or Foreign 85 Massachusetts 003-05-3947 Vrs Usuai Residenca of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2XXNo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 United States 712 Midland Road 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ② No
If Yes, Give
Year or Dates: 14. Raca - Amarican indian, Black, Whife, efc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) Police/Detective Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zerwick Julia **Black** Harry 19a. Informant'a Name/Relationship (Type, Pnnt) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2909 King St., Alexandria, Va. Terry Zerwick 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 5-19-98 Brentwood, Maryland Fort Lincoln Crematory 4 Donation → Other (Specify) 22. Nama and Addrass of Facility Hines-RinaldiFuneral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Maryland 20904 Hines-Kinaldifuneral Home, I Hampshire Ave., Silver Sprin

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, anock, or heart failure. List only one cause on each line. Approximate tmmediata Causa (Final disease or condition resulting in death) BUBBNOVISCULAR ACCIONT Dua to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical **Examiner**

permit. Pagas Department of Important: If It any injury or o

Physician

/Medical

Examiner

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Funeral

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"natural", or itema 23a or 28a-f show

Pagas 1 and 2 should be filed within 72 hours after death with 1 and of Haalih and Mental Hygiena.
Ant: If Item 27 is marked other than "natural", or Itema 23a or 3 and 10 or other thatmatic event, its Mental Earning man by nuy or other thatmatic event, its Mental and 10 and

Baltimore, Maryland 21215-0020

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Physician/Medical Examiner physician and the burial-transit USB BS by Completed paga 2 Be Certification: To

The law requires that the death certificate be executed

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24 hours after death.

Funeral Director: A

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Box 68760.

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Records,

Division of Vital or Attending Physician:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yes 200 25. Was case referred to medical examiner? 26. Placa of Daath (Check only one) 1 Yas 2 No Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28a. Date of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Naturai 1 ☐ Yes 2 ☐ No 2 Accidant 6 ☐ Could not be detarmined 3 ☐ Suicida 28e. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicida

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifi 1 Certifying Phyalcian: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier

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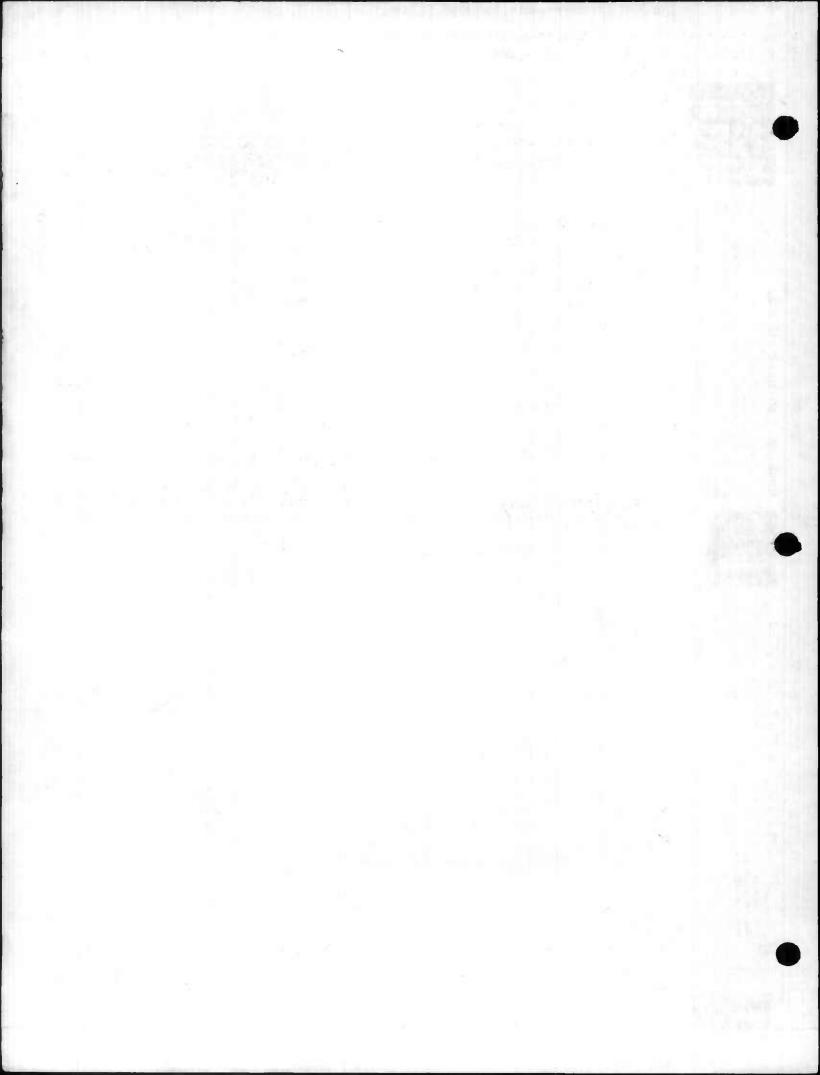
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CALL I WALGOLI, MO INIZS BOCKULLS PIKE, ROCKULLS MO 20852 31. Date filed (Month, Day, Year)

State Registrar

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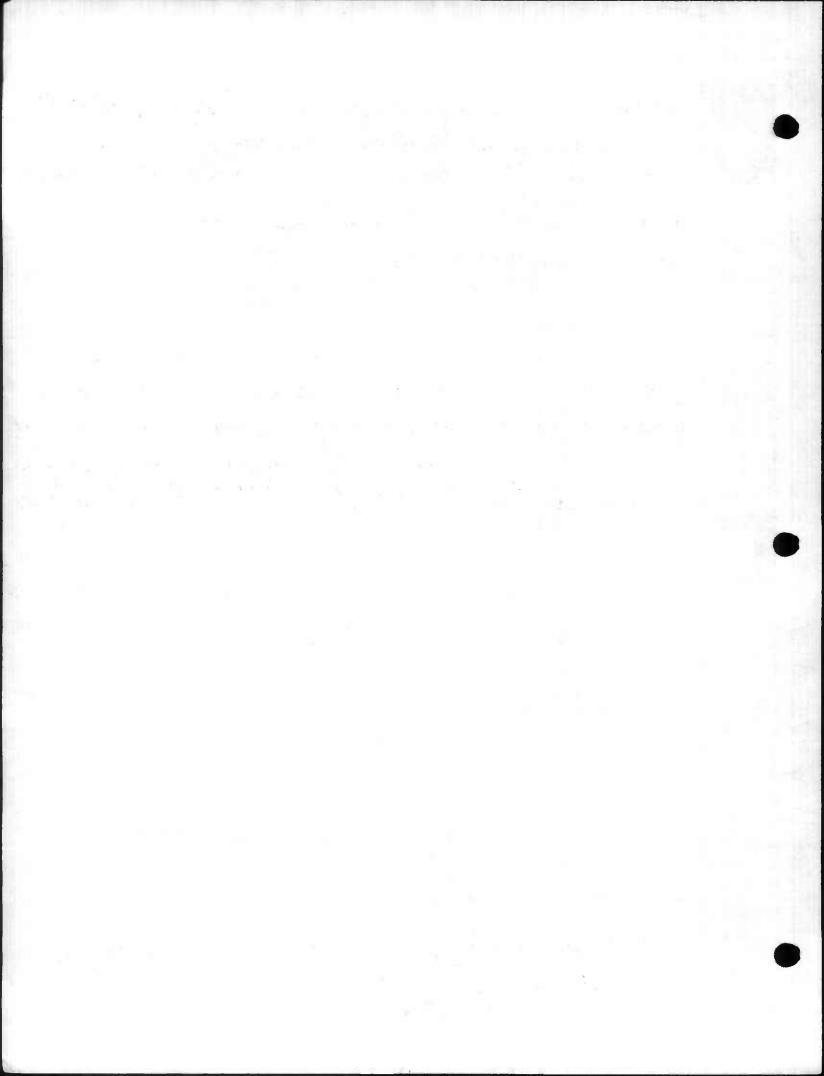




State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedant'a Nama (First, Middla, Last) Data of Death **Physician** RNET LEE /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) Examiner HOME BALTIMORE NURSING if Undar 1 Yaar Months Days if Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. iast birthday) Birthpiece (State or Foreign Country) 1□M 2☑F **Funeral** 217-40-926 54 Yrs. AUG. 29, 1943 NORTH CAROLINA Director Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 12 Yes 2 No BALTIMORE 101. Zip Coda Director MARYLAND 10e. Street end Number 10g. Citizan of What Country? 1613 PLACE APT# USA Funeral deeth 14. Rece - American Indian, Biack, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Merital Status filed within 72 hours efter 1 Yas 22 No it Yas, Giva Year or Dates: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1□ Yes 2₽No Specify: BLACK P 3 Widowed 4 □ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) ZYRS PN - NURSE FRANCIS SCOTT KEY other other traumatic avent, 18. Mother's Nama (First, Middla, Maidan Surnama) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If them 27 is marked oth-any injury or other traumatic avent 17. Fethar's Name (First, Middla, Last) ELLIOT WILKERSON 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ROAD BALTIHORE MO. 2/214 (SISTER) 523/ TRAYMORE LINDA WILEI Piace of Disposition (Nama of cemetary, crametory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Buriei 2 ☐ Cramation 3 ☐ Removal from State WOODLAWN CEMETERIGO1-98 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN AVE. BALTIMORE, MD. 21217 21. Signature of Funarai Sarvice Licensae 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximata intarval Between Onsat and Death Physician Immediata Causa (Final diseesa or condition rasulting In death) /Medical Cerebrel vascules Examiner Examiner Dua to (or es a consaquance ot): Sequentielly list conditions, if any, laeding to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Physician/Medical Be Dua to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 2 rigned by 1 | Yes 2 | No 3 | Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No Vital 25. Was casa ratarred to medical axaminar?

1 Yas 2 No Be 26. Place of Death (Check only ona) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 12 inpatient 2 ER/Outpatient 3 DOA After this 28a. Data of injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b Time of Certification: Division Attending 1 Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant i or Attend after deatl Director: 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifian 30. Nama and addrass of person who complated causa of death (item 23a) (Type, Print) 2434 & Betwedere are roul 10 Hogistress Signand Pandell 31. Data tiled (Month, Day, Year) State JUN 0 3 1998 Registrar



Physician /Medical Examiner The law requires that the death certificate be axecuted

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Baltimore, Maryland

Box 68760.

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Division of Vital Records,

or Attending Physician:

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To the Funeral Director: A completely filled in by the f

Diabetes 25. Was casa rafarrad to medical 26. Pleca of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 DInpatiant 2 ER/Outpatiant 3 DOA 27. Manner of Deeth 1 Naturei 28a. Deta of injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba 3 Suicida 28a. Piece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida 1 Certifying Physicien: To tha bast of my knowledge, deeth occurred at the time, deta and place, end due to the cause(s) and mennar as stetad.

2 Medicat Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and mennar stated. 29a. Certifiar (Check only one) 29b. Signatura and titia of cartifier 29c. Licansa number 29d. Data signad (Month, Day, Year)

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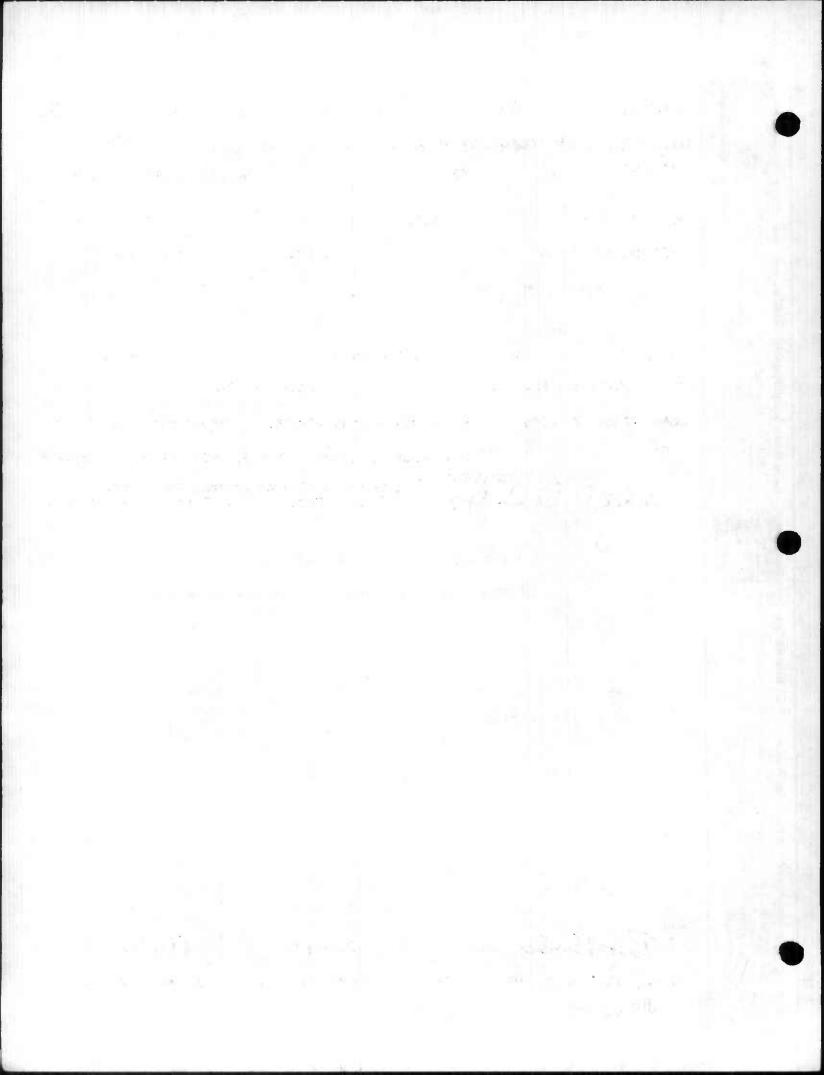
Registrar

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BORGHELT, MD S. GREENE ST, BALTIMORE, MD 22 33. Bagistrar's Signatura was Davidson-Randalle

Soulell, MD

30. Name end address of person who completed cause of daeth (Itam 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BRUENING 1998 CHRISTINE TUNE 11.30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Tan. 9, 1907 SAMARITAN HOSPITAL BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days t□M 2☑F 212-05-7802 Director Maryland Usual Residence of Decedent 10a. State 10b. County d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. fnside City Limits Rosedale Director 1 Yes 200No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 5509 Hamilton Avenue death v United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Biack, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3√ Widowed 4 Divorced Year or Dates: White Completed 15. Dacedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Sacondary (0-12) Coilage (1-4or 5+) Housewife Own Home 8 Years permit. Pages 1 and 2 should be filk Department of Health and Mentel Hy Important: if Itam 27 is marked oth any lijury or other treumetic event 900s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Hedl 70 Justine Unknown 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) Rosedale, Maryland 21206 5509 Hamilton Avenue Beverly Bruening Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 6/4/98 Baltimore, MD 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediete Causa (Finet disease or condition resulting in death) /Medical 48 hours Examiner Physician/Medical Examiner Pneumonia Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): hronic Pleura Due to (or as a consequence of) P.O. Box The law requires thet tha death certi-Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Dfd tobacco usa contribute to the cause of death? ate has been signed by page 2 should be detac Congestive heart 1 Yee 2 No 3 Probably 4 Unknown Records, by Completed 24b. Were autopsy findings available prior to completion of ceuse of daath? Digbeter mellitus 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No cartificate of Vital or Attending Physician: director. Be 25. Was cese referred to medical axaminar? 26. Placa of Daath (Check only one) Hospitai: 1 tnpatient 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this illed in by the funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Naturai s after death. 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 6 Could not be determined 28e. Piace of injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homfolde Hospital within 24 hours a edicai 1 🗹 Certifying Physician: To the bast of my knowledga, daath occurred at the time, data and piace, and due to the cause(s) and manner as statad. 29a, Certifier completaly (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. Licansa number

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31. Data filed (Month, Day, Year) State JUN 0 3 1998 Registrar

29b. Signature and titia of certifier

32. Registrar's Signature which Davidson Randall

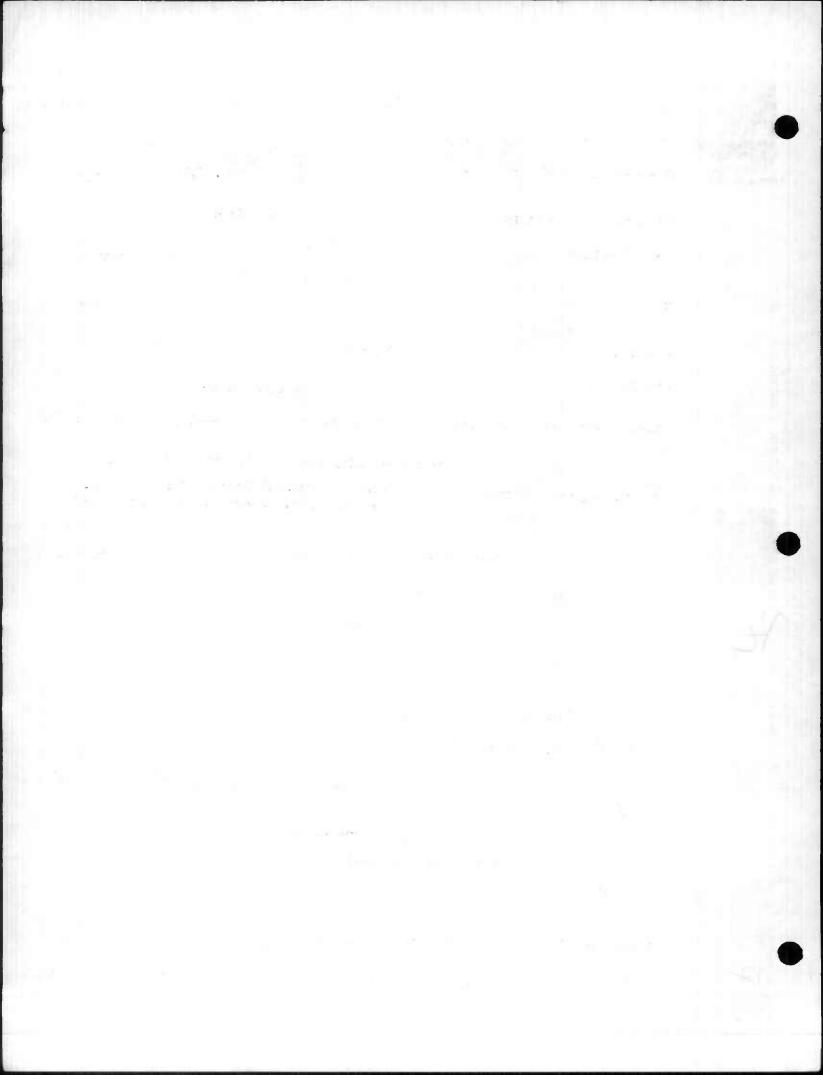
30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

M.D.

WILLIAM IMBEAH, GOOD SAMARITAN HOPPITAL, 5601 LOCH RAVEN BLVD, BALTO, MD 21239

29d. Dete signed (Month, Day, Year)

JUNE 1, 1998



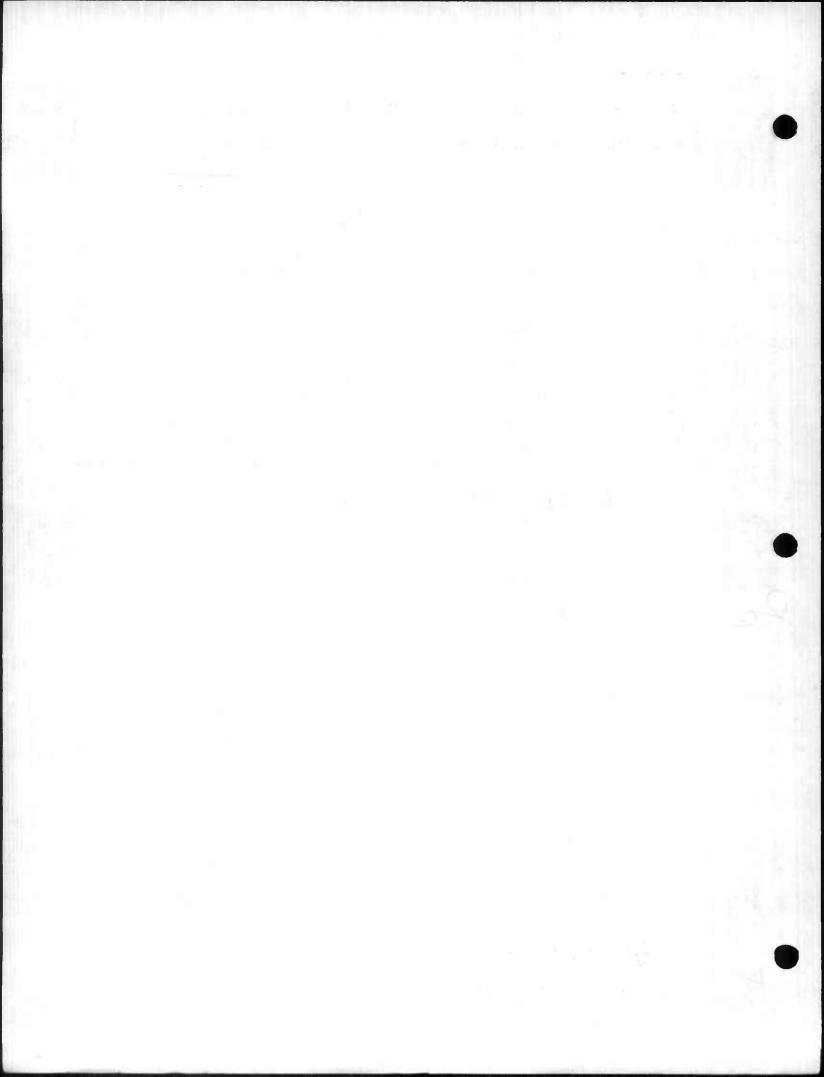
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #8 Per FH Film G760 6-4-98RC 1. Decedant's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Bunker **Physician** wight Odell 2005 NULY Thinketh /Medical 4e. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HO Spiral Center Randallston Northmort If Under 1 Yaer If Under 24 Hrs. 8. Deta of Birth
Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F 238-52-5215 Director Usuai Rasidance of Decedent 9-5-1937 with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If Is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Madical Examiner must be nothed at Baltimore 1 Yas 2 No OWINGS Director Ma 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5. 21117 Cour deeth 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Meritel Status 14. Rece - American Indian, Biack, Whita, atc. filed within 72 hours after 1 Never Merried 2 Merried 1 Yas 2 No Saltimore, Maryland 21215-0020 1 Yas 2 No Black Yes. Giva 2 3 Widowed 4 Divorced Yaer or Datas 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 18b. Kind of Business/Industry 1 versity Eiamantary/Secondary (0-12) end Mental Hyglene. Is marked other than Collega (1-4or 5+) Patient Transporter Mary land years 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Malden Sumame) permit. Peges 1 end 2 should be to Depertment of Health end Mental Important: If Item 27 is marked or any Injury or other traumatic ever JOSDET a 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Ildred Bunker Owings 18 Wyegate
20b. Piace of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, State cemetary, cremetory or other place) 1) Buriai 2 Cremetion 3 Ramoval from Stata Hemory Garden 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensaa 22. Neme end Addrass of Facility E. H 4300 Wabash Salto, red 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Causa (Final disaasa or condition rasulting in daath) /Medicai Aspirution Examiner Merastan Examiner CUNCER Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaase or injury that initieted avants resulting in daath) Lest Box 68760, attending physicia Physician/Medical Due to (or es a consequance of): certificate signed by the aid d be detached for P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 ☐ Yss 2 ☐ No Division of Vital Records. þ 24b. Wara autopsy findings Completed 24a. Was an autopsy peen available prior to completion of cause of death? performed? certificate hes 1 Yas 2 1No 1 Yes 20 No 25. Was casa rafarred to medical axaminar? Be 26. Pieca of Death (Check only ona) Other: 4 Nursing Homa Hospitai: J. 1 Yes 2 21No 1 Inpatiant 2 ER/Outpetient 3 DOA 5 ☐ Rasidence 8 ☐ Other (Specify) this 28a. Dete of injury (Month, Day 27. Mannar of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: To the Hospital or Attending P within 24 hours effer death.
To the Funerel Director: Affer I 1 Natural 5 Pending invastigation 1 Yas 2 No 2 ☐ Accident the 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Piace of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner so stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29e. Certifiar (Check only one) 29c. License number 29d. Deta signed (Month, Day, Year) 29b. Signetura and titia of cartifiar

State Registrar 30. Nama and addrass of person who completed cause of deeth (Itam 23a) (Type, Print)

31. Register's Signature

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Kevin 31. Date filad (Month, Day, Year)



4b. City, Town, or Location of Deeth

4c. County of Deeth

JOHNNIE	State of Maryland / Department of Health and Menta	l Hygien
BACKMON	Certificate of Death	Reg. N

		Ce	ertificate of Death		Reg. No.	30	1/1/3
1. Decedent's Neme (First, Middle, Last)				2. Dete of De	eth		3. Time of Deeth
JOHI	NNIE	THOMAS	BACKMON	Month MAY	30,	1998	7:23A.M.

/Medical Examiner

Director

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2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or its

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum pncs.

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Hospital 24 hours a Funeral

22 To the Villa 2

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P.O.

of Vital Records,

Division

Baltimore, Maryland 21215-0020

Physician

2907 TANEY ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) Deys Hours 10 M 20 F 67 Yrs 248-44-4178 3-29-1931 S.C.

Director Usuel Residence of Decedent the Maryland 10e. Stete 77 is marked other than "natural", or fems 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

Backmon

4e Facility Neme (If not institution, give street end number)

10b. County 10c. City, Town or Location 10d. fnside City Limits tXYes 2 □ No Md N/A Baltimore

10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 2907 Taney Road 21209 Funeral

US Α 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritel Stetus 1XXYes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 N Merried 1 Yes 2 No Specify: Specify: Black

 Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+) N/A 8th grade mentary/Secondary (0-12)

Foreman Bethlehem Steel 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme)

Elizabeth Daniels 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

Virginia E. Backmon - Wife Baltimore, Md 21209 2907 Taney Road

20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition ₩XBuriel 2 Cremetion 3 Removel from State Garrison Forest 4 ☐ Donetion 5 ☐ Other (Specify) Vet 6-3-98 Owings Mills, Md

21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
March F/H West Baltimore, Md 21215

Enter the times of complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart Nurre. List only one cause on each line. Approximete Intervel Between Onset and Deeth

Immediate Cause (Final disease or condition resulting to death)

Johnnie

3 Widowed 4 Divorced

Arteriosclerotic Cardiovascular Disease

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of)

Due to (or es e consequence of)

Pert tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t.

23b. Dfd tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Diabetes Mellitus

24b. Were eutopsy findings eveilebte prior to 24e. Wes en autopsy completion of cause of deeth?

1 ☐ Yes 2 No 1 Yes 2 No 25. Wes cese referred to medicel examiner? 26. Place of Deeth (Check only one)

Hospitel: Other: 4 ☐ Nursing Home 5 NResidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. tnjury et Work?

5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide

1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Yeer)

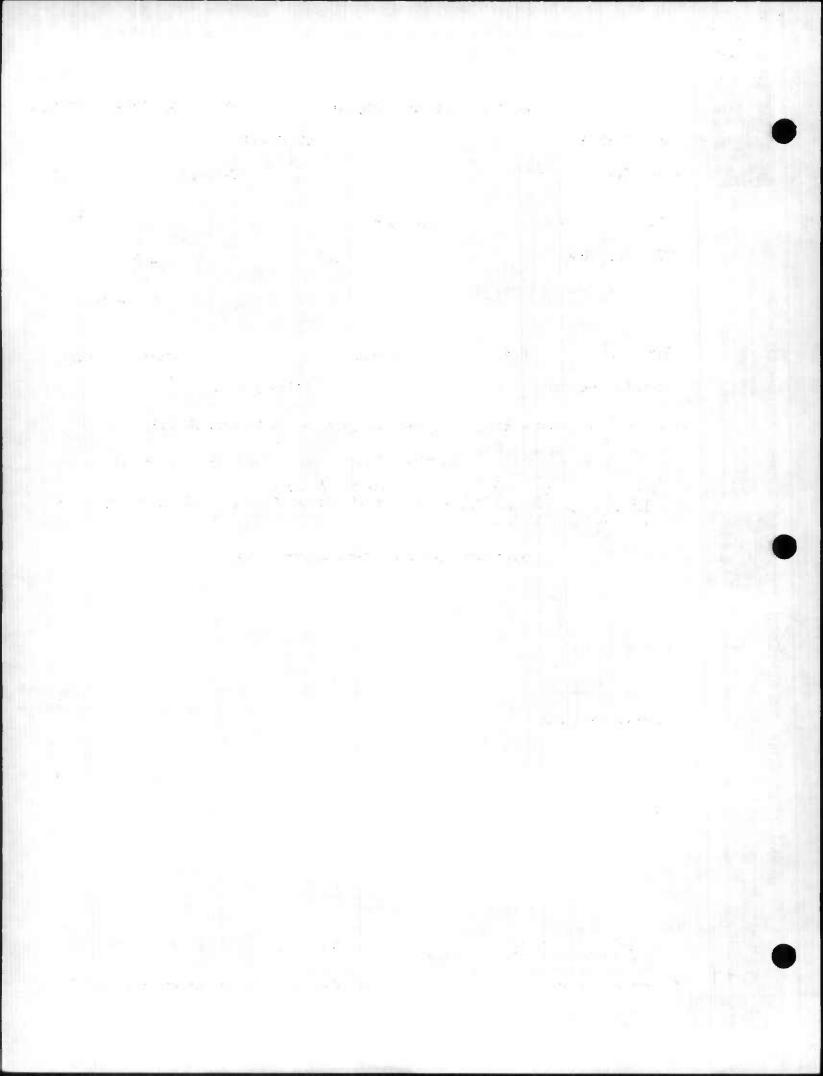
O.C.M.E. JUNE 1,1998 ans

30. Neme and address of person who completed caus of deeth (Item 23e) (Type, Print)

Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Month, Day, Year)

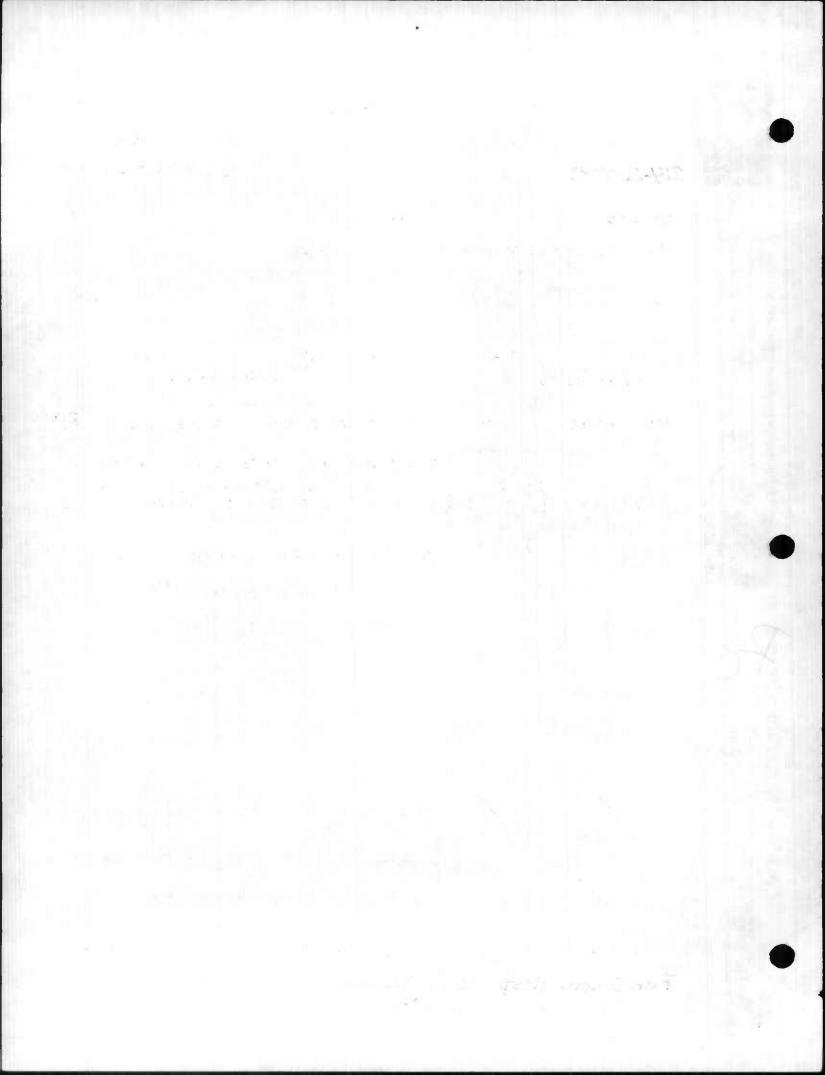
32. Registrer's Signeture Likia Davidson JUN 0 3 1998



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Physician /Medical	MA	BLE	C.	BA	GLE		2. Dete of Dea Month	Day	Year 10:43AM
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Funeral Director		Sex 7. Age (i	n yrs. lest birtho 85 Yr	Month:		If Under 24 Hrs. Hours Min.		2,1912	9. Birthplece (State or Foreign Country) VIRGINIA
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cto cto	MARYLAND N/	I	BALTIMORE					1⊠Yes 2□No	
23a or 28a-f si	10e. Street and Number 1027 N. CATH	EDRAL STRE					201		A.
at, or items 23a or 28a-f show Examine must be notified at by Funeral Director	3 ₩ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No If Yes, Give		 13. Was Decedent of Hispanic Origin? (Specify Yes or if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 ☐ Yes 2 ☐ No Specify: 			14. Race Black Specify:	- American Indien, c, White, etc. NEGRO
"natur	15. Decedent's E (Specify only highest gra Elamantary/Secondary (0-12)	ducetion ade completed) College (1-4or 5+)	16e. D		suai Occupat work done du usa retired)	ion iring most of wo	rking	16b. Kind of But	siness/industry
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s marked sumatic s	19a. tnforment's Name/Ralationship (Type, Print)	19b. N	Mailing Addra	ss (Street ar	nd Number or Re	ural Route Numbe	r, City or Town,	
tam 27 other tra	ALVIN BAGLEY	/ SON				CIRCL	E APT.		TO, MD: 21244
E &	20a. Method of Disposition 1 Burial 2 Cremation 3			crematory or	r other place		Date		City or Town, State
ortant: Injury 8.	4 Donation 5 Other (Special 21. Signature of Funeral Service Lices		ARBUT	22. Name	and Address	of Facility			TO, MD.
Par y	CALVIN B. SCRUGGS FUNERAL HOME								
	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. pono	enter the m	ode of dying	, such es cerdia	c or respiratory ar	rast,	Approximata Intarval Between
sician edical niner	immediate Cause (Final disease or condition resulting In death)	a				IAL.	INFAR	Petio,	Onset and Death
ner			e to (or as a co	NA	Ey /	4RTER	4 1015	EASE	1
n and tel-transit Examiner	Sequentially list conditions, if env. jeading to immediate	Due to (or as e consequence of): DIABETES ME LUITUS.							
S E	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated avants	C				ME	LUITU	15.	
We at	resurting in death) Last	d	e to (or as a cor	isequence of	1):				
etached fo (use Physician/N	Part II. Other significant conditions of	contributing to death but r	ot resulting In t	ne underlying	g ceuse give	n in Part i.	23b. Dld 1	obacco use con	tribute to the cause of death?
							10	res 2 No	3 ☐ Probably 4 ☐ Unknown
2 should pleted			<u> </u>					en eutopsy med?	24b. Were autopsy findings available prior to completion of cause of daath?
Com							1 🗆 1	es 2 No	1 ☐ Yes 2 ☐ No
director, par o Be Co		Hospital:	аПтрю. II	-W 201	Other	,.	ath (Check only o		(0
After this formation of transcal or throngon or the throngon or throngon or throngon or the throngon or th		28a. Date of Injury (Month, Day Y	1 M inpatient 2 LER/Outpatlent 3 LDOA 4 LI Nursing Hom			ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred			
the Funeral Director: After in inpletely filled in by the funeral Aedical Certification:	3 Suicide 6 Could not be datarmined	- At home, farm Specify)	larm, street, factory, offica 28f. Location City or 1			28f. Location (S City or Tox	n (Street and Number or Rural Route Number, Town, State)		
B 75		yalcian: To the bast of n niner: On the basis of ax end menner stete	amination and/	laath occurre or Investigation	ed at tha time on, in my opi	, data and place nion, daath occu	e, and due to tha urred at the time,	causa(s) and mai data and place, e	nnar as stated. and dua to tha cause(s)
dictory dictory	one)								
completely filled in Medical Cert	29b. Signature and title of certifier		-	2	29c. License	number		29d. Date signed	(Month, Day, Year)
To the Fur completely Medica		d. luit	0 M	n. 2	D 2				(Month, Day, Year)
To the Funeral completely file.		completed cause of deat		/pe, Print)		548	L V223		1

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 98 17175

				Ce	ertificate o	f Death		Reg. No.	0	1110	
		1. Decedent's Nama (First, Middle, L.		2. Date of Death Month Day Year							
	Physician /Medical	Elizabeth Ann Bavis						JUNE 2, 1998 1:59			
	Examiner	4a Facility Name (If not Institution, gi Saint Joseph		4b. City, Town, or Location of Death Towson Ba			imore				
	Funeral Director		Sex 7. Ag 1 ☐ M: 2 🖾 F	Age (In yrs. last birthday) H Under 1 Year If Under 2 Months Days Hours			8. Date of Bi (Month, De June 3	th y, Year) , 1928		ace (Stata or Foreign fry) land	
and and	Mo to	10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits	
Man	a or 28e-f ahow be nottiled at Director	Maryland N/A		Baltim	ore City					1 X Yes 2 □ No	
th th	or 28 Manat	10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?				
ath w	23a matt	1230 Woodbourne			21239				United States		
Maryland 21215-0020	and Mantal Hygiena. Is marked other than "natural", or itema 23a or 28a-f ahow aumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forcas	Armed Forcas? 1 Yes 2 XNo If Yes, Give		 Was Decedent of Hispanic Origin? (Specify of Yes, specify Cuban, Mexicen, Puerto Rican) Yas 2 No Specify: 			y Yes or No- en, atc.) 14. Race - American India Black, White, atc. Specify: White		
5-0	"natural", adical Em	15. Decedent's E (Specify only highest gi	ducetion ade completed)	16a. Dec	edent's Usual Occ re kind of work dor	cupation ne during most of wo ired)	orking	16b. Kind of B	usinass/Ind	ustry	
121	han. Mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	. DO NOT use reti Teacher's			Priva	ite Sc	chool	
d 2	Hygie ther t	12 17. Father's Name (First, Middle, Las	1)		reachers		me (First, Middle	, Meiden Suman	ne)		
an an	Mental prices atic eve To Be					Irer	ne Cara	Nippar	rd		
Maryla 2 should	th and Mental Hygiena. 7 is marked other than traumatic event, the M. To Be Comp	19a. Informant's Name/Relationship		19b. Ma	iling Address (Stre	et and Number or R	ural Route Numb	per, City or Town	State, Zip	Code)	
2 0		Norman F. Bavis,	Sr. / Hus	band 12	30 Woodb	ourne Ave	. Balti	more, M	aryla	nd 21239	
imore Pages 1	nent of ant: If it ury or o	20a. Method of Disposition 1 X Burlal 2 Cramation 3 C 4 Donation 5 Other (Special Content of Cont			position (Name of emetory or other p illey Mem.		Date 6/5/1998	20c. Location		wn, Stata Maryland	
Balt permit.	Department important: If any injury o	21. Signature of Funeral Sarvice Lice	ing/	2301		rford Rd.	Baltimo				
		23a. Part1. Enter tha disaasa, or con shock, or heart failure. List only	plications that cause one ceuse on each	d tha death. Do not e	nter the mode of d	lying, such as cerdia	c or respiratory a	arrest,		Approximete Interval Betwaan	
j = l	nysician 'Medical xaminer	immediate Cause (Final disease or condition	INFERI	OR MYOCA	RDIAL 1	NFARCTI	ON			Onsat and Death 1 DAY	
		resulting in death)		Due to (or as a consequence of):							
O, executed	physician and as the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.									
ords, P.O. Box 68760, requires that the death certificate be executed	ding physici se as the bu	resulting In death) Last	c	Due to (or as a conse	equence of):						
Bo)	d by the attend etached for us Physiclan/		0						1		
O. \$	igned by the a be detached i	Part II. Other significant conditions	contributing to death I	but not resulting in the	underlying ceuse	givan in Part I.		Yee 2 No		the cause of death?	
S, P	igned be deta							2,410	00,110		
Records,	The law requires tate has been sign page 2 should by						24a. Wa: perf	s an autopsy ormed?	cor	ere autopsy findings ailable prior to mplation of causa death?	
I Rec	page page Com						10	Yes 2 No	10	Yas 2 No	
Vital	s certificate director, pag To Be Co	25. Was case referred to medicel examiner?					eath (Check only	one)			
Phy O	Phys ral di	1 ☐ Yes 2 No 27. Manner of Death 1 Naturel 5 ☐ Pending	Hospital: Inpat 28a. Date of Inj (Month, De	ury 28b. Time	of 28c. In	njury at Vork?	Home 5 ☐ Res 28d. Describe	how injury occu)	
Division i or Attending	the the	2 Accident investigation 3 Suicide 6 Could not determined	28e. Place of In	njury - At home, farm, stc. (Specify)		Yes 2 No	28f. Location City or To	(Street end Num own, Stete)	ber or Rura	I Route Number,	
- Hospitai	within 24 hours after or To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier Certifying P	nyaician: To the best miner: On the basis of and manner s	of my knowledge, de- of examination and/or tated.	ath occurred at the Investigation, in m	time, date and pled y opinion, death occ	e, and due to the surred at the time	cause(s) and m , date and place,	enner as st and due to	ated. the ceuse(s)	
To the	vithin To the comp	29b. Signature and title of cedifies	- 10	, M7	1	anse number		29d. Data signa	od (Month)	Day, Year)	
) /		30. Name and address of person who	completed ceuse of	death (Item 23a) (Typ		T-C-T		0/2	17	8	
(0	TIMOTHY LOW, M	I.D., 762	20 YORK R		DWSON, M	ARYLANI	2120	94		
	State	31. Date filed (Mooth, Day, Year)		a Dividson-A	indell_						

DHMH 16 Rev 6/95

State Registrar

발생님 집에는 열차하다 중요 그는 것이다.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** 6:25 pm Blum June Margery 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ballins Johns Hopking Hormital If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Jan. 1, 1921 5. Social Sacurity Number 9. Birthpiaca (Stata or Foraign Country) Colorado 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 F Director 454-26-8703 Usuat Rasidance of Decedant 10a. Stata 10c. City, Town or Location 10d. fnslde City Limits 10b. County itam 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be nothing at 11 Yas 2 □ No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7 Brooke Avenue 21401 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after c. Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mental DEC. 1 Navar Married 2 X Married Specify: White 1 ☐ Yas 2X No Specify PV 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own Home 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Sadie Block Simon Light 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 7 Brooke Avenue, Annapolis, MD 21401 Morris Henry Blum - Husband 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Kneseth Israel Cemetery 06/03 Annapolis, MD 22. Nama and Addrass of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disalsa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** * Preumonia /Medical Immediata Causa (Final disaasa or condition rasulting In daath) Examiner Dua to (or as a consaquance of): Examiner hronic Sleunid attending physician end for use as the burief-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Embolus ulmonary Physician/Medical Dua to (or as a consequence of) olymyosi his Part tl. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cutaneous lupus by 24b. Wara autopsy findings available prior to Au pothyroidism 24a. Was an autopsy performed? Completed complation of cause of death? After this certificata hes Acid Maltase Deficiency 2 00 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 26. Piaca of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 1 Yas 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. fnjury at Work? Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of injury - At homa, farm, straat, factory, offica building, atc. (Specify)

that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified

with the Marylend

death

10

Cynthia Boyd 31. Data filed (Month, Day, Year) JUN 0 3 1998

29b. Signatura and titla of certifian

Centhia Boyd

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

4 ☐ Homicida

(Check only one)

29a. Cartifian

edical

State Registrar

110 32. Ragistrar's Signatura Julia Davidson

Touci

Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

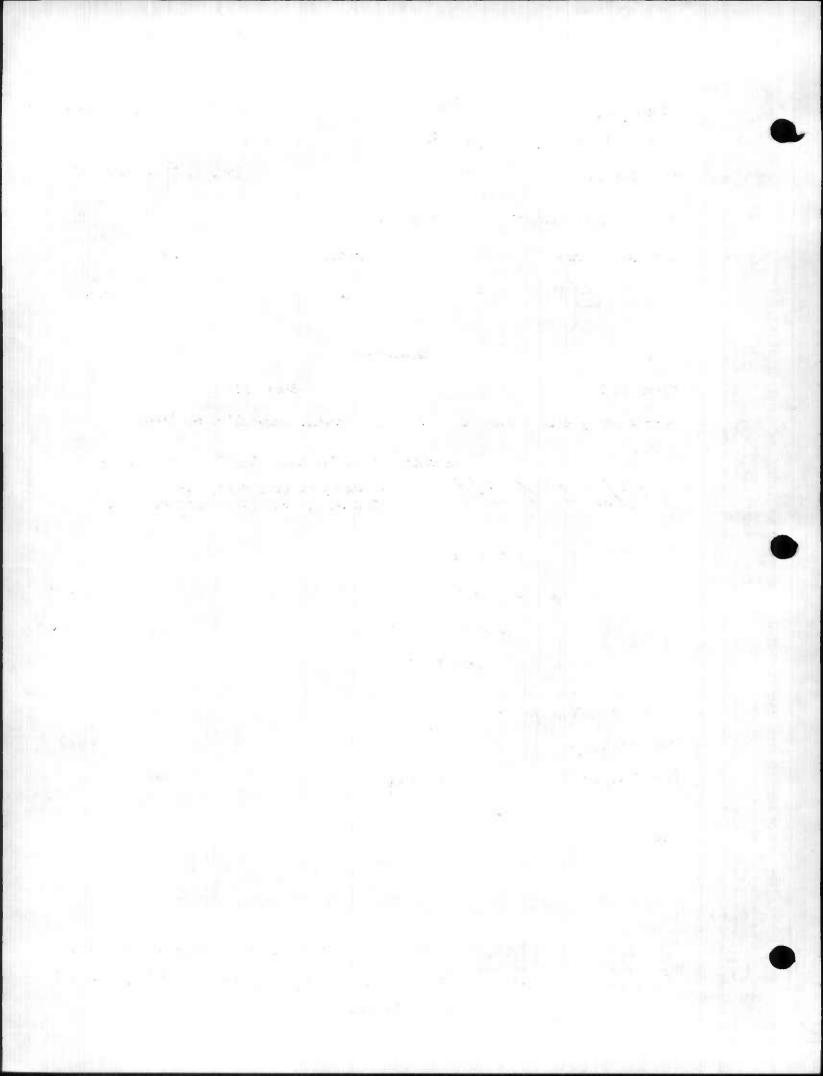
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

RES-000

Johns Hopkins

29d. Data signed (Month, Day, Year)



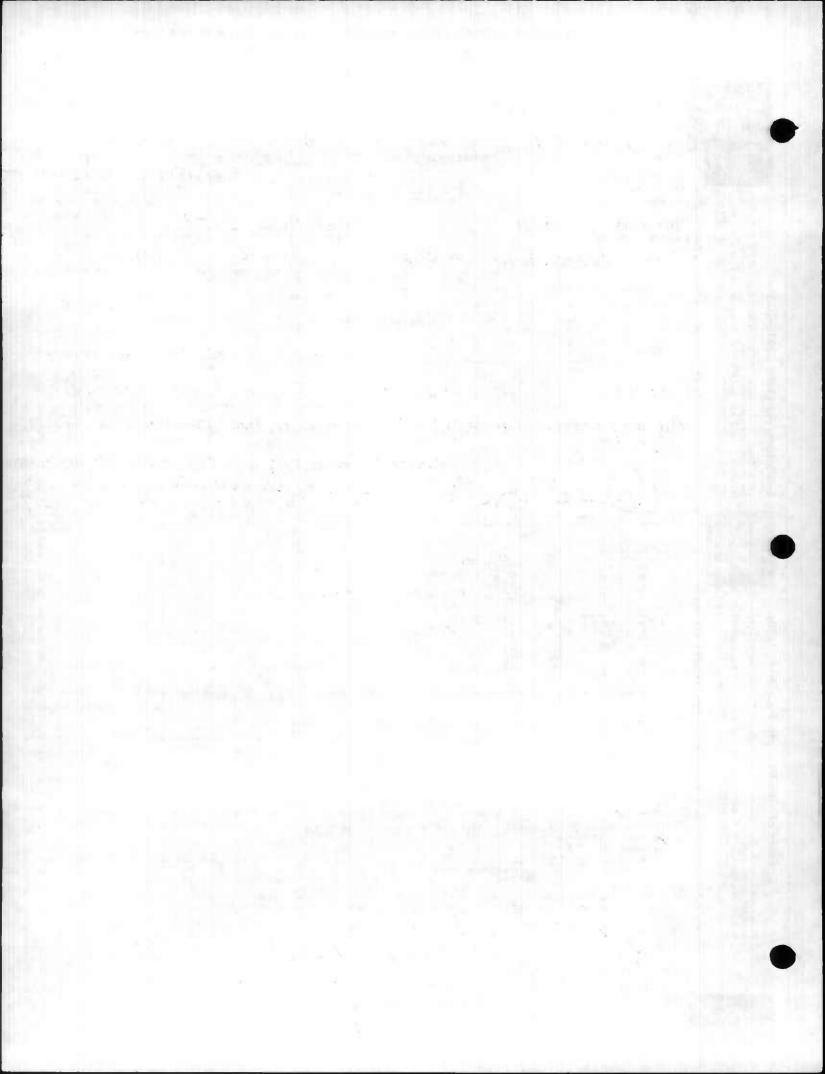
State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** Mari 150 pm 5 Carroll /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Maryland Medical System | Baltimore Baltimore Universit If Under 24 Hrs. 6. Date of Birth Hours Min. (Month, Day, 7. Age (In yrs 5. Social Security Number Birthplace (Stata or Foreign Country) **Funeral** 1 M 2 F Days UNKNOWN MARVI **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE Directo MARYLAND 10e. Street and Number 10g. Citizan of What Country? "natural", or items 23a or edical Examiner must be r 2705 AVENUE USA, WESTWOOD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK þ 3 ₩ Widowed 4 Divorced the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within ntal Hygiene. od other than swent, the M Elamentary/Secondary (0-12) College (1-4or 5+) +4 GRADE WORKER PRIVATE DOMESTIC permit. Pages 1 and 2 should be tile.
Department of Health and Mental Hys.
Important: if hem 27 is marked other any injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surname) Be FAUNTLEROY (MN-UNKNOWN 2 JOHN 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) DAUGHTEL) 2705 WESTWOOD AVE. BALTIMORE, MD. 21216

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State HUDREY WARREN 20a. Method of Disposition

Description

Removal from State 20b. Placa of Disposition (Name of cametery, crematory or other place) ARBUTUS CEMETERY BALTIHORE, HARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility DOWN JR. FUNER AL HOME PA JOSEPH H. BROWN JR. FUNER AL HOME PA 2140 N. FULTON AVE. BALTIHORE, HD. 21217 JOSEPH 2140A Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory a shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in daath) /Medical Examiner Physician/Medicai Examiner Cranta physician and s the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consaquence of) 88 attending I for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? has been signed by the ga 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy performed? After this certificate he funeral director, paga 1 ☐ Yes 2 No 1 Yes 2 No Be or Attending Physician: 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yas 2 No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be datermined 3 Sulcide 28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifi ess of person who complated cause of death (Itam 23a) (Type, Print) Meryland Med of lichael C. 32. Registrar 31. Date filed (Month, Day, Year) State JUN 0 3 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Veer **Physician** н. 4b. City, Town, or Location of Death LOUIS CLARKSON 4c. County of Death /Medical 29. 1840 4a. Facility Nama (If not institution, giva street and number) Examiner SAL., MD. Wicomico Salisbury Center, Genesis ElderCAre 5. Social Sacurity Number 215-16-7845 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. 8. Date of Birth
(Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months 113 M 2□ F Yrs 08-27-1923 Maryland Director Usuel Residence of Decedent the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXXVo Director Virginia Accomack Chincoteague 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be 5343 McClary Drive 23336 death Funeral United States 12. Was Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - Amarican Indian, Black, White, etc. 72 hours efter 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: by 3 ☐ Widowed 4 € Divorced WWII White Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7 Years Steelworker Steel Industry 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 should be f end Mental I Charles V. Clarkson Hedwig M. Kroll 0 permit. Peges 1 end 2 sh Department of Health end Important: if Item 27 is m any Injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Howley Daughter 8312 Cove Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serwice Corp. 6/4/98 Towson, Maryland 21. Signature of Fyneral Sarvice Licansee 22. Nama and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. 23a. Part1. Enter the display shock, or haart failer. Approximate Intarval Between Physician /Medical Immadiata Cause (Final one Day Neumonno disease or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Diseese or Injury that initiated events resulting in deeth) Lest Bnd Due to (or as a consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown been signed be should be dete Records, þ 24b. Were autopsy findings availabla prior to complation of causa of death? 24a. Was an eutopsy performed? Completed my Antes Diserose WASC 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificete Division of Vital 25. Was case referred to medical axaminer? Hospital or Attending Physician: 24 hours efter death. director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No Certification: To 28a. Date of Injury (Month, Day Yaar) funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 6 Could not be determined 3 D Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homlcide To the Hospital o within 24 hours eff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar 29c. Licansa number MIST MO 30. Name and eddress of person who completed cause of death (Item 23e) (Type Print) Dune, SAles my 21804

State Registrar

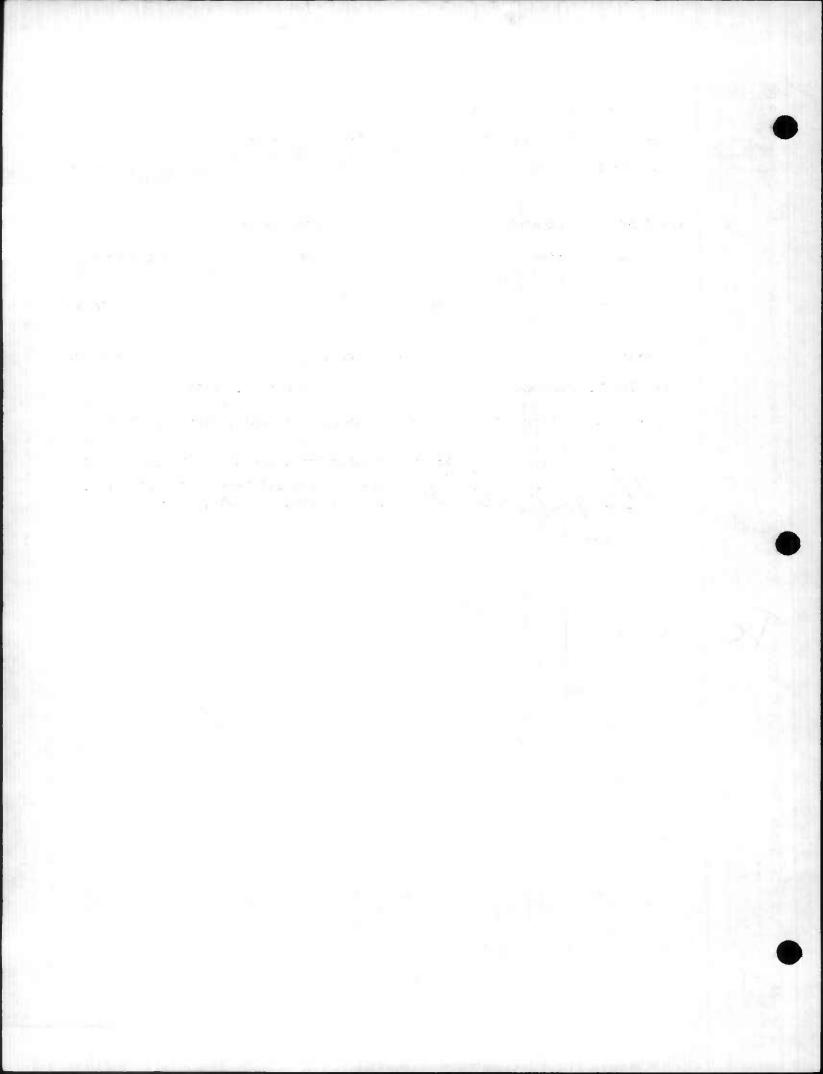
JUN 0 3 1998

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Suna Davidson-Randala

DHMH 16 Rev 6/95



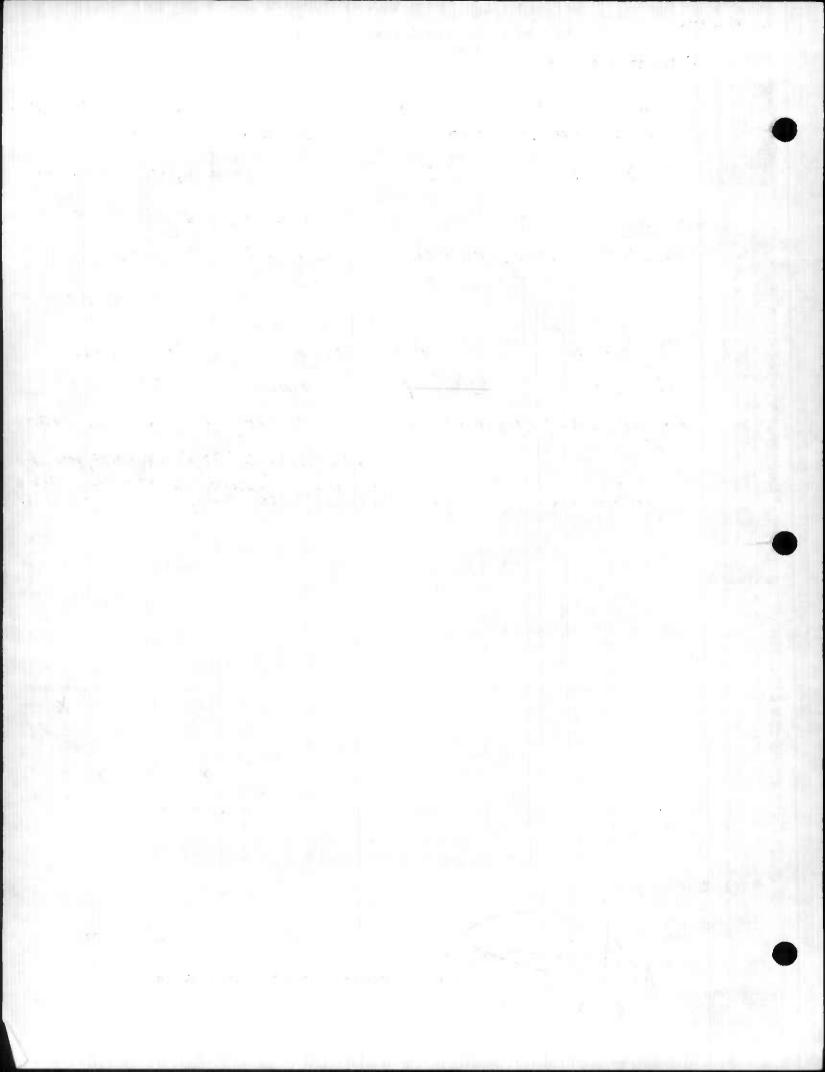
111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Dey, Year)

JUN 0 3 1998

32. Registrer's Signeture

whit Davidson-Tandelle



State of Maryland / Department of Health and Mental Hygiene

JAMES	CAMPBELL

Directo

Funeral

by

ASP

otate of maryland	, Dopartinont of Floatti and	monta, riygiono	1 / 1 32 11
4a,26 per MEO G-760 6/2/98 reb	Certificate of Death	Reg. No.	1/180
onl's Name (First, Middle, Last)		Date of Death Month Dey Year	3. Time of Deel

Physician /Medical Examiner

Funeral

Director the Maryler r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at death

e filed within 72 hours efter al Hygiene. other than "natural", or ite traumetic event, 12 should be fi end Mental F Is marked of

> 80 USB (certificate has this unaral After completaly 2

Baltimore, Maryland 21215-0020 Completed Be permit. Pages 1 and 2 sh Department of Health end Important: If Itam 27 Is m any Injury or other traum page. **Physician** /Medical Examiner Examiner physician end s the buriel-transit certificate be axecuted Box 68760, Physician/Medical P.O. g Division of Vital Records, Completed Be 2 Certification: i or Attending safter death. d Director: Aft To the Hospital within 24 hours a To the Funeral C edicai

Items: 1. Decede CAMPBELL **JAMES** C. MAY 1998 4b. City, Town, or Location of Deeth 4c. County of Di 4a Fecility Name (If not institution, give street and number) 7780 SHAREWOOD 7780 SHERWOOD DRIVE JESSUP If Under 24 Hrs. 6. Sex 10 M 2□ F If Under 1 Year 8. Dele of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Deys Hours Min Yrs. 219-80-1976 37 27,1961 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County HOWARD **JESSUP** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20794 U.S.A. 7711 HELEN WAY 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, atc. 1 □XYes 2 □ No If Yes, Give 1 Never Married 2 Married 1 Yes 2√ No Specify: If Yes, Give Year or Detes: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) RACING COMMISSION 12TH GRADE SECURITY OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) THOMAS E. CAMPBELL MARCINE BETTY LAIRD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) WENDELL E. CAMPBELL (BROTHER) 7900 TALL PINES COURT - GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) GLEN HAVEN CEMETERY 05/28/98 GLEN BURNIE, MD 22. Name end Address of Facility
HUBBARD FUNERAL HOME INC. 21. Signe un di Funeral Service Licensee 4107 WILKENS AVENUE-BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Shotgen wound of abdomes Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lesl Due to (or es a consequence of): Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.

25. Was case referred to medical exeminer? Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yas 2□ No 27 Manner of Deeth 28b. Time of 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending Investigation 2 Accident

5-23-98 6 Could not be determined

0300 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

Other: 4 Nursing Home 5 Presidence (V)Other (Specify) SCENE 28c. Injury at Work? injury

1 Yes 2 No

Subject shot self 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1780 Sharewood Drive Jessup, Howard Court, MD

28d. Describe how Injury occurred

24a. Was en eutopsy performed?

26. Place of Death (Check only one)

1 X Yes 2 □ No

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated.

**TMedical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Wonald & Wright MD

O.C.M.E

29c. License number

29d. Dete signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 2□ No

3:00

10d. Inside City Limits

Approximate Interval Between Onset end Death

1 ☐ Yes X☐ No

MAY 23,1998

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD G. WRIGHTMD

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dale filed (Month, Dey, Year) MAY 2,81998

3 Suicide

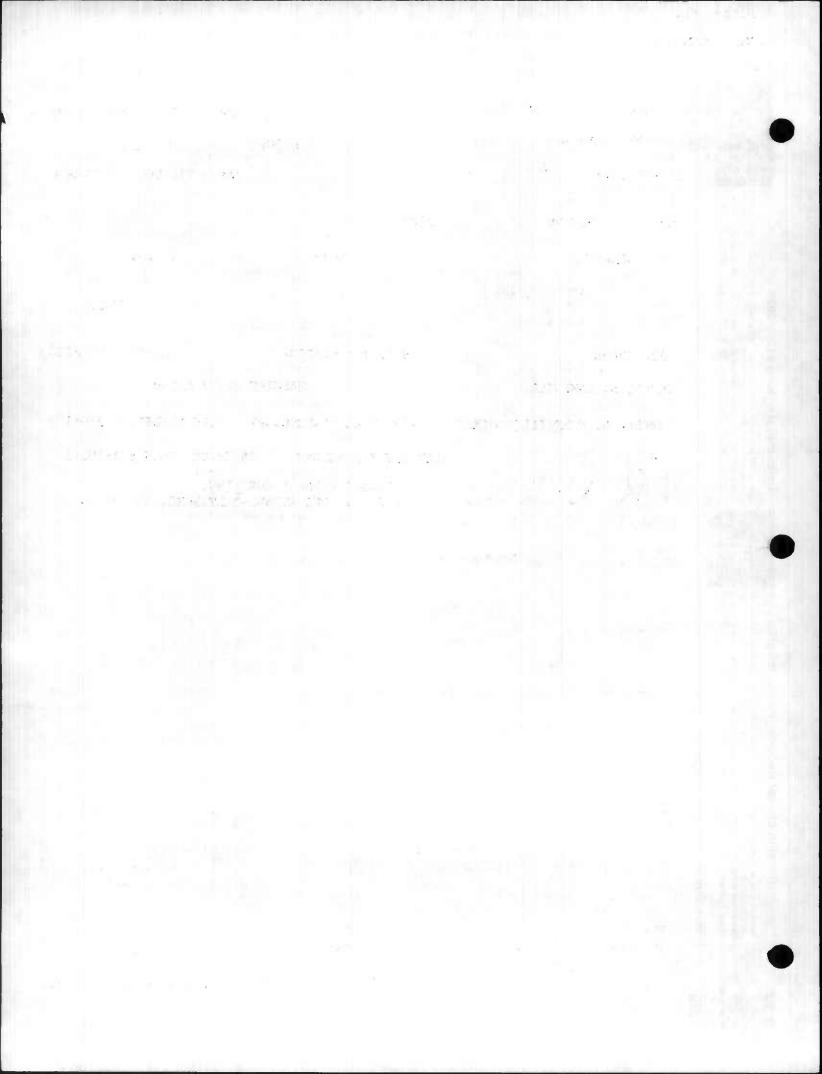
29e. Certifler

4 Homicide

(Check only one)

29b. Signature and little of certifier





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ASP Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** Minkalo L. Cabeza MAY 30 1998 12:00 * /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street end number) 4h. City. Town, or Location of Death Examiner n/a MARYLAND SHOCK TRAUMA If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Dete of Birth (Month, Day, Year) Funeral 10 M 2□ F Months Deys Hours Min 219-04-7460 22 Yrs. Director Dec. 23, 1975 Md. Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Exercises result to notified all Md. n/a Baltimore 1XXes 2□No Director 10f. Zip Code 21229 10e. Street and Number 10g. Citizen of Whet Country? with USA 4620 Frederick Avenue death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 225No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Black, Whita, etc. 2 should be filed within 72 hours after a end Mantel Hygiene. Is marked other than "natural", or item Never Married 2☐ Merried Baltimore, Maryland 21215-0020 TYPY 2 No Specify: Spaniard Specify: Spanish þ 3 Widowed 4 Divorced Completed 16s. Decedant's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) n/a n/a 10th Grade 18. Mother's Neme (First, Middle, Meidan Sumeme) 17. Fether's Neme (First, Middle, Last) Be Catherine Edmunds Pedro L. Cabeza 19b. Meiling Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) father permit. Pages 1 end 2 sh Depertment of Health end Important: If Item 27 Is m any Injury or other traum once. Pedro L. Cabeza 4620 Frederick Avenue Baltimore, Md. 21229 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Mathod of Disposition Burial 2 Crametion 3 Removel from State June 4 Baltimore, Md. Western Star Cemetery 22. Name end Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service License 2501 Gwynns Falls PKWY Baltimore, Md. 21216 mes un 23a. Pert1. Enter the diseese, or complication shock, or heert teilure. List only one cell ad tha daeth. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Interval Between Onset and Deeth **Physician** Immediata Causa (Final diseese or condition resulting in daath) /Medical Examiner Due to (or es e consequença of): Examiner Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disaesa or Injury that initieted avants resulting In deeth) Lest Due to (or es e consequença of): Physician/Medical Box 6878 Due to (or es e consequenca of) 88 980 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown Records,

signed by the e peed has

director this unerel After 1

P Completed Be 2 Certification: filled in by

or Attending deeth. after deeth Director: 24 hours 8 Hospital To the I within 2

Division of Vital

25. Wes case referred to medical exeminer? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA 28a. Date of injury (Month, Day Year) 28b. Time of Injury 5 Panding

5.29.98 investigation 6 Could not be datarmined

32. Registrar's Signatur

28a. Place of Injury - At homa, farm, streat, fectory, offica building, atc. (Specify)

Other: 4 Nursing Home 5 Rasldenca 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

26. Piace of Daath (Check only one)

bjer 5 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

24e. Wes en eutopsy

performed'

Yes

28d. Describe how injury occurred

4921 1 Cartifying Physician: To the best of my knowledge, daeth occurred et tha time, dete end pleca, and dua to tha ausa(s) and manner as stated. Madical Examinar: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

2 No

29b. Signeture end title of certifie

Year?

JUN 0 3 1998

29c. License number O.C.M.E

Brokett.

29d. Date signed (Month, Dey, Year) 30,1998 MAY

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 Yes 2□ No

d cause of death (Nem 23e) (Type, Print) 30. Neme and editur

111 Penn Baltimore, Maryland 21201

31. Dete filed (Month. State Registrar

Medicai

1 Yes 2 No

27. Manner of Death

1 Neturel

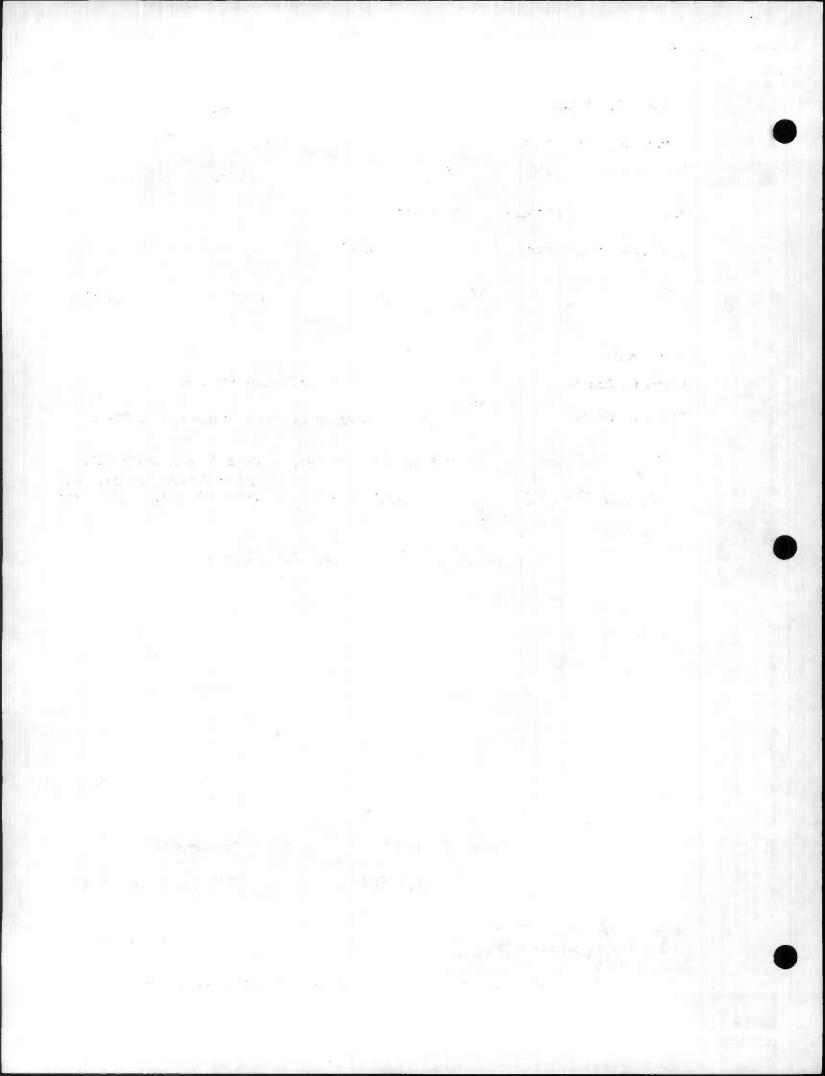
2 Accident

3 ☐ Suicida

29a. Certifier

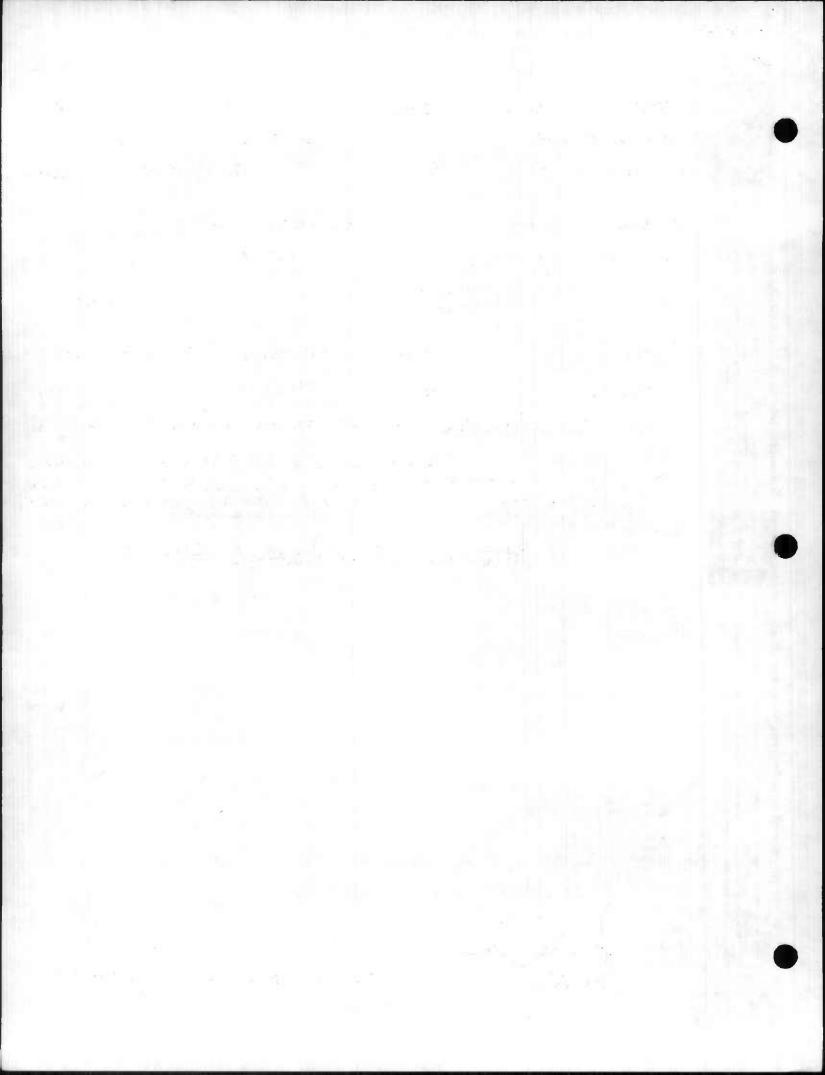
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(Check only one)



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	EORGE					Certificate o	f Death		Reg. No.	0	1186
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П	Physic	an				DEMDCEV		Month MAY	30,19	Year	30P.M.
	· /Medi		4a Facility Name (If not institution, giv	EDWARD		DEMPSEY	4b. City, Town, or I	1			JUI .II.
A	Exami	ner	910 N. PAYSON STRE				BALTIMO		40. Oddiny		
					Marina la	ast hirthday) If Under 1 Yes			th	N/A	Ctata or Farsian
в	Funeral		5. Social Security Number 6. S	M 2□ F	(in yrs. ii	Ast birthday) If Under 1 Yes Months Dey		Month, Pa	Year)	Country)	State or Foreign
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	pue M		10a. State 10b. County		10c. Clty	, Town or Location	-			10d. In	side City Limits
	Aery Pery	0	MADILLAMA A	1/2		B	- 11005	· M.	7/	11	PYes 2□No
	28e	Director	10e. Street and Number	11		10f. Zip Code	TIMORE	- 01	100. Citizen of V	What Country?	
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	effer death with the Meryland or items 23s or 28s-4 show	Funeral	910 N. PA	12. Was Decedent Ev		13 Was Decedent of	Hispanic Origin? (S	inacity Yes or No	14 Bac	a - American Inc	dian.
		'n	11. Marital Status 1 ☐ Newer Married 2 ☐ Married	Armed Forces?		13. Was Decedent of If Yes, specify Co	ban, Mexican, Puert	o Ricen, etc.)	Blac	ck, White, etc.	
20		by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates: //	0-27	1 Yes 201	o Specify:		Specify	BIA	OV
Ö	naturel',	P	15. Decedent's Ed	16	0-11	16a. Decedent's Usuel Occ	upation		16b. Kind of Bu	usiness/Industry	
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12	be filed within tal Hygiene. d other than event, the M	mc	Elementery/Secondary (0-12) 8 THGRADE	College (1-4or 5+)	TRUCK DRIV	ED HEL	DEP	SUPER	MARK	KET
	offled other	Ö	17. Father's Name (First, Middle, Last)			THUCK OKI			, Maiden Surnam		
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			23a Part 1 Inler the disease, or com shoot or heart failure. List only	plications that ceused to one cause on each line	he death	. Do not enter the mode of o	lylng, such es cardia	c or respiratory a	rest,	Appr	roximate vel Between
١,	Physician			Λ			1				et and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	Mato	080	lhote Ca	solbraso	was 8	2,8842	3	
į,	Examiner		resulting in deeth)	" 1 Jost "	ue to (or	es e consequence of):					
-	D #	Examiner		h							
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ita	certificate rector, per	Be (25. Was cese referred to medical examiner?				26. Place of De	ath (Check only	one)		
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	ding Ph After th funeral		27. Menner of Deeth 1 Natural 5 ☐ Pending	28a. Dete of Injury (Month, Dey	Year)	28b. Time of 28c. In Injury	jury at vork?	28d. Describe	how Injury occur	red	
0	Attending r death. ector: Afte by the fune	atic	2 Accident investigation	n	50.		☐ Yes 2 ☐ No				
Division	or Attendation of Director:	tific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injur building, etc.	y - At ho	me, farm, street, factory, offic	> 0		(Street and Numb wn, State)	ber or Rural Rou	ite Number,
ō	a afte	Certification:			, , , , ,						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Cartifying Ph	yaician: To the best of	my knov	viedge, death occurred at the	time, date and place	e, and due to the	cause(s) and made	anner as stated.	rause(s)
	he H in 24 he Fi	edical	one)	and manner state		on and/or investigation, in the	y opinion, death occi	ar the thire	date and place,	and doe to the	2000(3)
	To With To Moo	Σ	29b. Signature end title of certifle	_)			ense number	2	29d. Date signe		Year)
	121			< >x_		0.0	C.M.E.		MAY 31,	1998	
	47		30. Name and addry person who	completed cause of dec	eth (Item	23e) (Type, Print)					01000
			min	XON		111 Pe	enn Street	, Balti	more, Ma	aryland	21201
	Sta		31. Date filed (Norlth, Day, Year)	32. Register	A. S	50 V. 100					
	Regist	rar	JUN 0 3 19	398 P gu	may Do	widson Aandelle					
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DHMH 16 Rev 6/95



SHIRLEY THOMAS

Funeral

Director

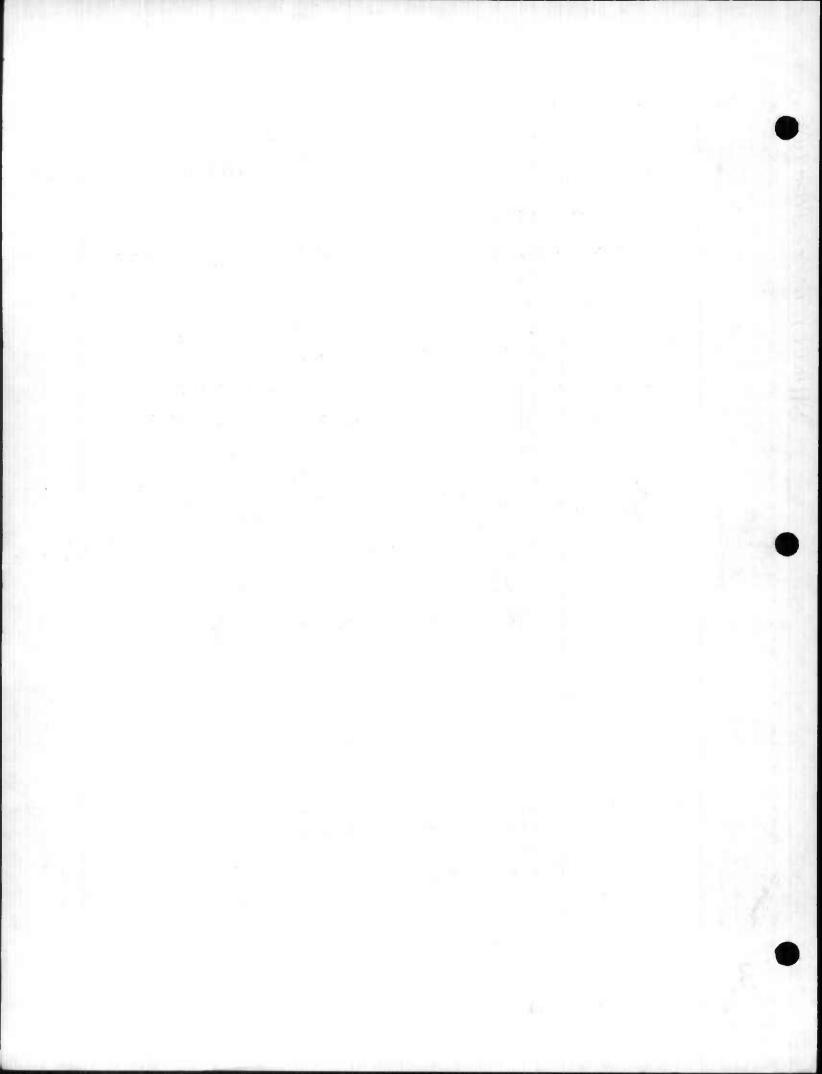
288-1

Examiner must be r

permit. Pagas 1 and 2 should be filed within 72 hours after death: Department of Haelth and Mental Hygiana. Important: If flem 27 is marked other than "natural", or items 23, any injury or other traumatic event, the Medical Examinan material. **Physician** Immediete Cause (Final disease or condition resulting In deeth) /Medicai Examiner Examiner physician and the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Physician/Medical 80 for usa P.O. Division of Vital Records, þ Sign Be Completed paga 2 or Attending Physician: 25. Was case referred to medical exeminer? Be 1 Yes 2 No Certification: To this funaral 27. Menner of Death 1 Neturel 5 Pending Investigation after daath. 2 Accident 6 Could not be determined 3 Suicide filled in by 4 | Homicide 24 hours a Hospitai 29a. Certifier complataly (Check only one) within 2 the

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SHIRLEY T. DASHIELDS 06, May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 200F 242-19-9670 **Vrs** 33 04/22/1965 N. Carolina Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE MD LAUREL 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 14 SHARON COURT, #302 20707 U.S.A. Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 200 Married 1 ☐ Yes 2 No Specify: **Black** by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry AJ Contracting College (1-4or 5+) Elementery/Secondary (0-12) Accountant 12th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Leon Thomas Robie Mosley 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Charles S. Dashields 14 Sharon Court, #302, Laurel, MD 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 6/1/98 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LEROY O. DYETT & SON FUNERAL HOME, 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ist only one cause on each line. evim Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Tyes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) Medical 1🗹 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end placa, end due to the ceuse(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29d. Daye signed (Month, Day, Year) 29b. Signature end title of certifier ceuse of deeth (Item 23e) (Type, Print) 30. Neme end eddress Dus State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Defa of Death 3. Time of Death 1. Decedant's Neme (First, Middle, Last) JUNE 01, Dey EVERETT **Physician** ICHARD 1998 17:40 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs 9/Birthplece (Stele or Foreign 7. Age (In yrs, last birthday) Months Deys 74-3278 10 M 2 F Yrs Usual Residence of Decedent 10a. State 10b. County Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo nore Vland Mar 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 10 a Funeral Was Decedent Eve Armed Forcas? 1 XYes 2 ☐ No If Yes, Give Yeer or Dates: 11. Maritel Status Ever in U,S . Wes Decedant of Hispanic Origin? (Specify Yas or No ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece Amarican Indian Bleck, White, atc. 1 Never Married 2 Married 1□ Yes 20 No Specify: Slack þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life_DO NOT use retired) ; 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) ondary (0-12) op (1-4or 5+) a ac/Eiret Mintella 18. Mot Be 10 1 Surial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify) 3 DRemoval from State 21. Signature of Funeral Service Lice S 2/2/6 222 North Ave In Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, occ. or heart feiture. List only one cause on each line. Approximete Interval Batween Onset and Deeth UREMIA Immediete Cause (Finel disease or condition resulting in deeth) 24 HOURS Due to (or es e consequence of) Physician/Medicai Examiner 7 DMYS ROWAL FAILURG Sequentially tist conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury thef initiated events rasulting in deeth) Lest Due to (or es e consequence of) DAYS SOPSIS Due to (or es e consequence of) 1 MONTH PROM HN-ROLATED IMMUNOSUPPROJSION IMMUNOS UPPRESSION 23b. Did tobacco use contributs to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 □ Probably 4 □ Unknown 1 Yee MIV/ MOS þ 24b. Ware eutopsy findings evelleble prior to complation of causa of deeth? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatienf 3 □ DOA 28d. Describe how injury occurred 27. Menner of Deeth 28h Time of Certification:

Examiner The law requires that the death certificate be executed attending physician end for use es the burief-transit Division of Vital Records, P.O. Box 68760, ed by the a signed by t should I After this certificate hes introduced the second of the se Hospital or Attanding Physician: I Director: A death within 24 hours efter To the Funeral Direc completely filled in by efter

Funeral

Director

show

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Executer maint be notified at

Peges 1 and 2 should be filed within 72 hours efter death nent of Health and Mentel Hygiene.

Department of Health a Important: If Itam 27 Is any Injury or other tra

Physician

/Medical

Baltimore, Maryland 21215-0020

with the Maryland

28c. Injury ef Work? 1 A Neturel
2 Accident 5 Pending invastigation 1 Yes 2 No 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Phyercian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es steted.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end mennar stated. 29e. Certifier (Check only one)

29b. Signature and fitte of certifian Meyerel 29c. License number REJ-000

29d. Dete signed (Month, Day, Year) 6/1/98

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) 600 N WOLFE ST., BALTIMORE, MD. 21287 DARIN L. WEYRICH MD THE JOHNS HOPKINS HOSPITAL

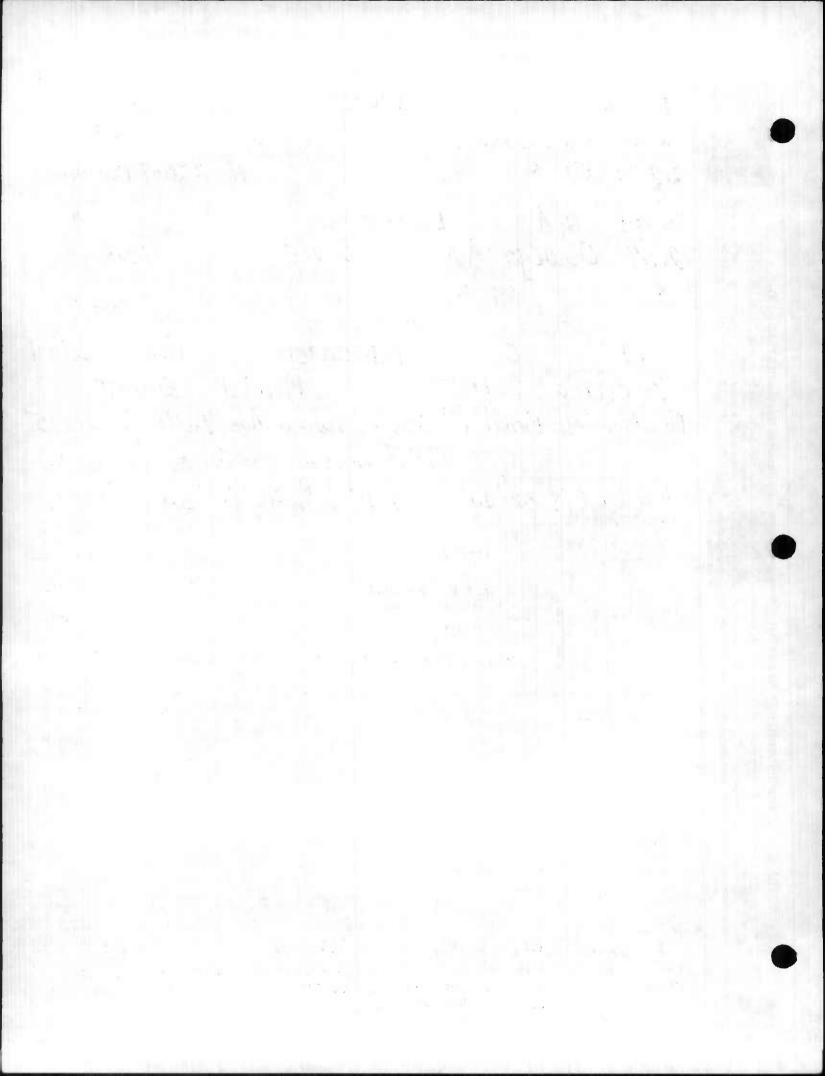
State Registrar

Medical

31. Dete filed (Month, Dex, Year)

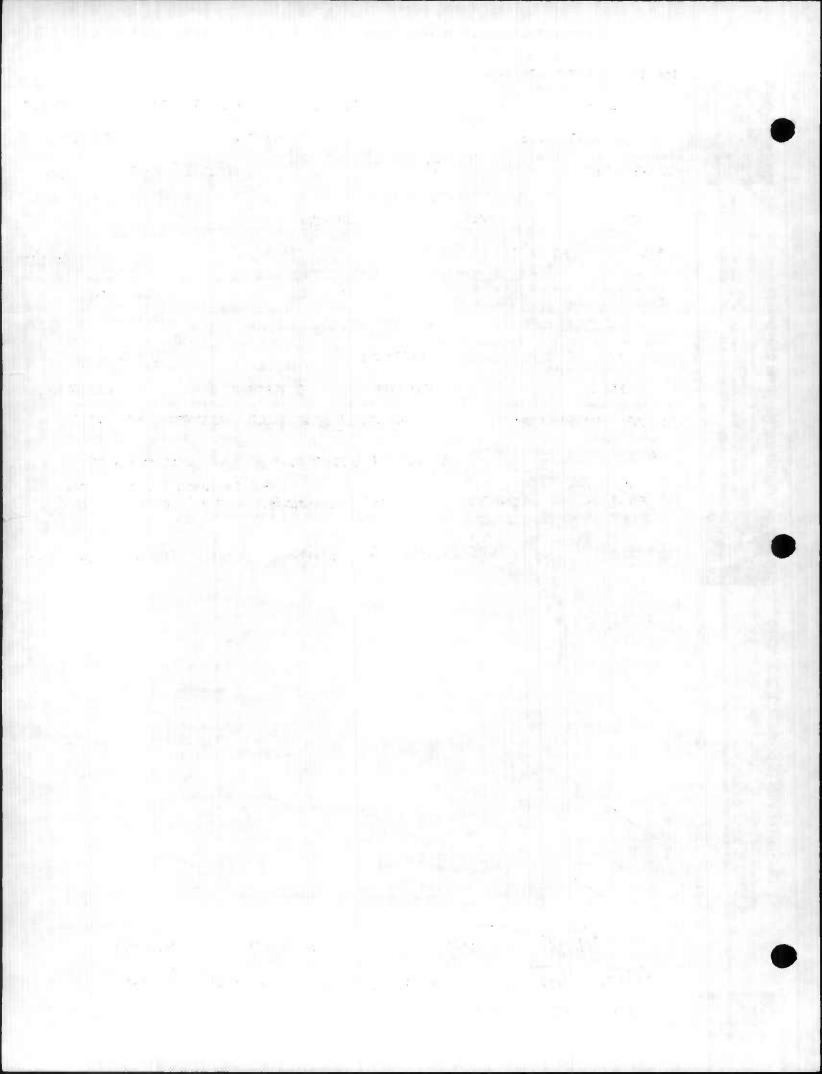
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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		. Decedent's Nam	ne (First, Midd	lla, Last)						177		2. Date of D Month		Year		e of Death
Physician /Medical		D	ELLA						ELIN	-		MAY 3	-	98	5:4	10 A.N
Examiner	4.0	a Facility Name (If not institutio	-		ımber)				4b.	City, Town, or I		4c. 0	County of De	eth BALTIM	ORE
Funeral Director	5.	Social Security N		6. Sex	M 21XF	7. Age (I	In yrs. la	ast birthday) 1 Yrs.	If Under 1 Ye		If Under 24 Hrs. Houra Min.	8. Date of E (Month, L APRIL	irth Year)		irthplace (Sta Country)	
ahow	-	sual Residence d 0a. Stata	10b. County	у		10	Oc. City,	, Town or Lo	ocation						10d. Insid	e City Limi
28a-fah notified rector		MD			ľ	N/A			BALTI	EMOR	RE				178	/as 2□N
0 2 0	10	0e. Street and Nu 3615 FO		NE :	#609				10f. Zip Cod	le	21215		10g. Citiz	ten of What (J.S.A
al', or items 234 Examiner must by Funeral	5	1. Marital Status 1 ☐ Never Man 3 🏿 Widowed		rried	2. Waa Dad Armed Fo 1 Tes If Yes, Gi Year or I	orces?	ar In U,S		Was Decedent of Yes, specify C		panic Origin? (S Mexican, Puert Specify:	pecify Yas or No Ricen, etc.)		4. Race - Arr Black, Wh Specify:		١,
Hygiene. where then "naturnent, the Medical Completed		(Specification)	15. Deceder cify only highe ondary (0-12)	est grade	completed)) (1-4or 5+)		16a. Deced (Give life. L		cupati ne du tired)	on ring most of wor	king		nd of Busines	s/Industry	
e ser	17	7. Father's Name	(First, Middle,	, Last)				THE		1	8. Mother's Nan	ne (First, Midd				
T ST OF			LLIS				I	FRIBUS	-		LILLIAN				LANDSM	IAN
g = g		9a. Informant's N SHIRLEY				1					Number or Ru				21215	
other other	-	0a. Method of Dis	sposition	•			20b. Pla	ace of Dispo	clarks La sition (Name of matory or other	f		Data		cation - City of		9
	0	Donation 2	☐ Cremation 5 ☐ Other (5	3 ∐Re Specify)	movai from	State			HEBREV			5/2/98	BALT	IMORE,	MD	
Department Important: I any Injury o pnce.	21	1. Signature of Fi	uneral Service	License	6.11	111		22	2. Name and Ad	idress	of Facility	Levin	son &	Bros.	, Inc.	
	2	23a. Part1. Enter	tha disaase, o	r complic t only one	ations that	ceused the	e death.	. Do not ent	8900 Rei	iste dying,	erstown such as cerdiad	Road B or respiratory	altimo arrest,	ore, M	Approxi)8 mate Between
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Month-LUNK 4b Sity, Town, or Location of Death 4c. County of Death 4/10 N/A De cours OITAL If Under 1 Year If Under 24 Hrs 7 Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Year) Months Days Hours 1 M 2 K F Yrs.

38 /Medical 4a Facility Name (If not institution, give street and number) **Examiner** Social Sacurity Number Birthplace (State or Foreign Country) **Funeral** 176-12-6702 75 Director Aug. 26, 1922 PA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28s-f show traumatic event, the Medical Examinar name be notified at 1 Yas 2 □ No Director N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2629 Lehman Street 21223 United States Funeral death 12. Was Decedant Evar In U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after Hygiena. 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: 1 Never Married Married "natural", or [1 Yes 2KN0 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementery/Secondary (0-12) College (1-4or 5+) 12th N/A Confectionery Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 12 should be fi h and Mental H Is marked ot William Uriah Lint Bertha Irene Frye 19a. Informant's Name/Retationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n Charles N. Funk, Sr. /Husband 2629 Lehman Street, Baltimore Maryland 21230 Baltimore, 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition Date XX Burial 2 Cremation 3 Removal from Stata 6 Crownsville Veterans Cemetery June 4, 1998 Crownsville Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Servica Licansee Victor P. Doda, Jr. 1501 E. Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Shouth one /Medical Immediate Cause (Finat disease or condition resulting in death) Sepsio Examiner Due to (or as a consequence of) app me Examiner menmonia attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es a consequence of): app one Box 68760, resistent Stoph. oursers mosth Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the 1 Yes 2 No 3 Probably 4 Unknown signed by by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen concer 1 ☐ Yes 2 No this certificate 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? or Attending Physician: Be 28. Ptece of Death (Check only one) Hospital: Other: 4 Nyrsing Home 5 Residence 6 Other (Specify) To the Hospine.

Within 24 hours after death.

To the Funeral Director: After this c 9 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 5 Pending 1 Netural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifiar 29c. License number -40521 June 1, 1998 3350 Wilkens Arenue Suite 302 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. OCHANE Beltimore, no 21279

32 Registrar's Signeture
Julia Davidson-Randone

State

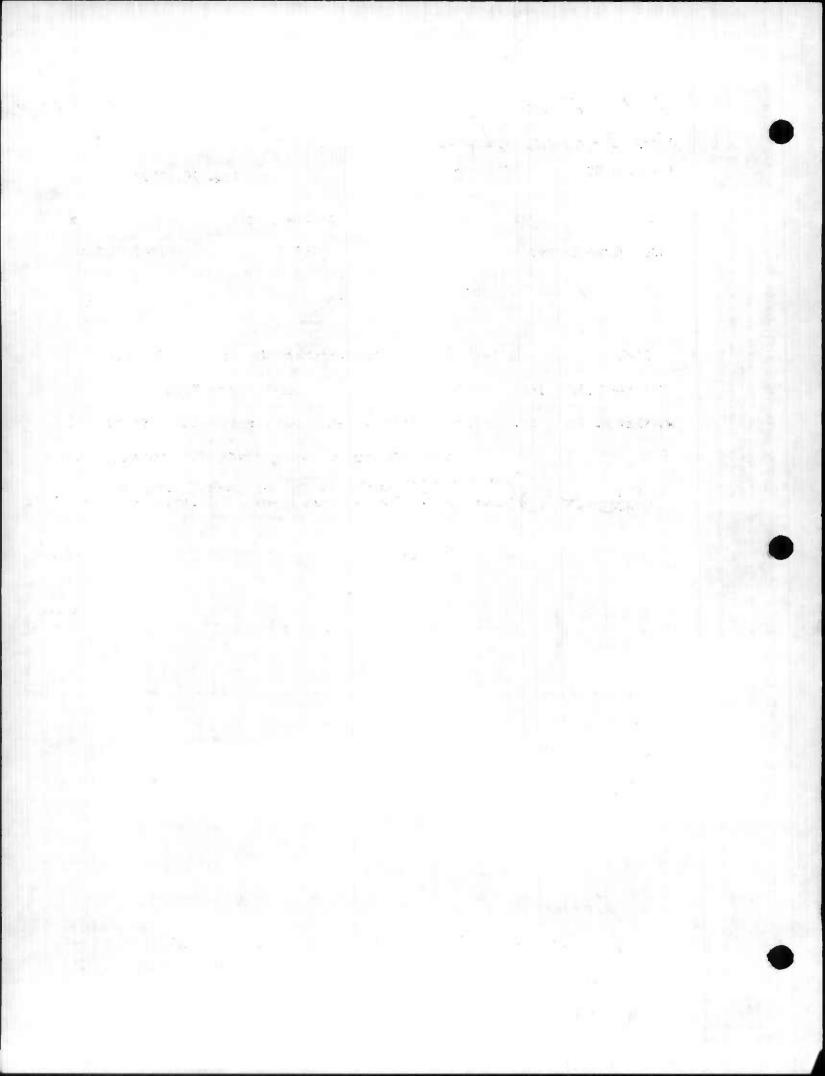
Registrar

31. Date filed (Month, Dey, Yeer)

JUN 0 3 1998

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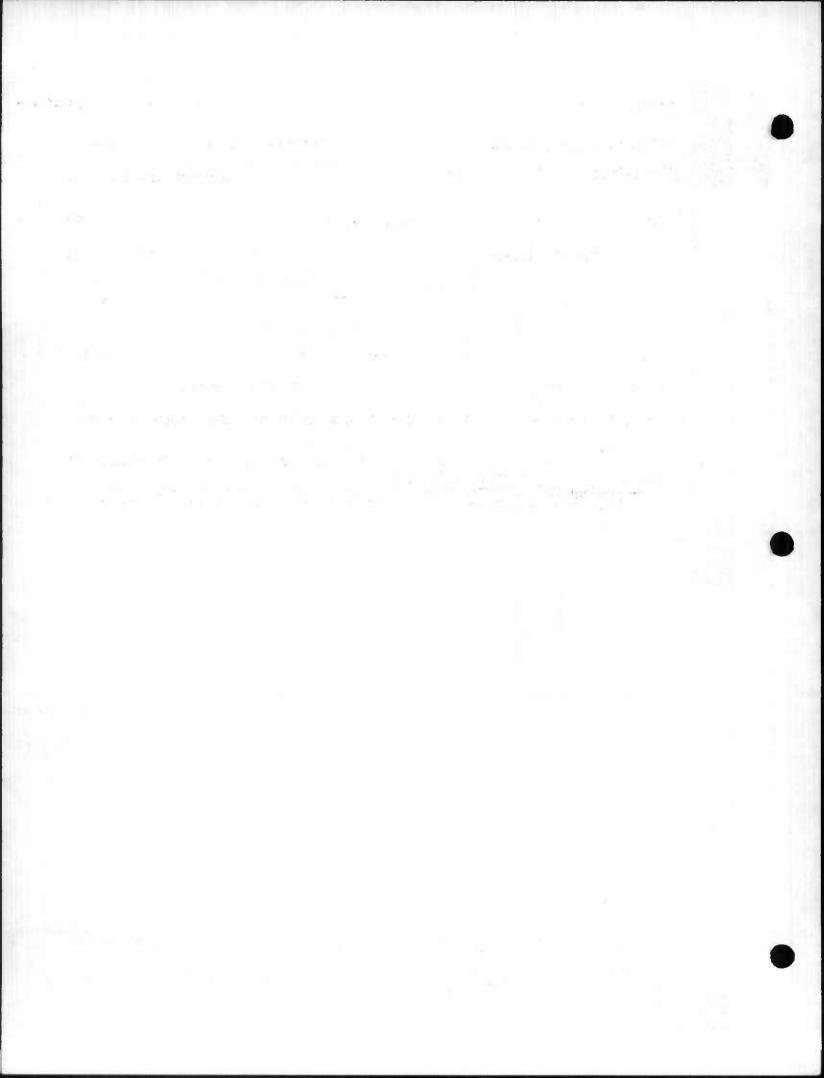
Physician



Please Type or Print In Black indelible ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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0	Exami		4e. Fecility Nema (If not institution, gir	va street and number)				4b. City, To	own, or Lo	ocation of Deeth	4c. County	y of Death		
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į.	Funeral Director		215-01-7594	OTH OTH	n yrs. last birthdaj Yrs.	Months	Days		24 Hrs. Min,	(Month, De)	y, Year) per 25,	Cour	place (Stata or Fi htry) MD	oraigi
	pue Mari		Usual Residence of Decedent 10a. Stata 10b. County	10	Dc. City, Town or I	Location						1	0d. Inside City L	lmits
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	23a or 2	ral Dir	10e. Street end Number 115 W. Randall	l Street		10f. Zlp	Coda		2123		10g. Citizan of Unit	what Cour ed St		
020	2 should be filed within 72 hours siter death with the Maryland .end Mental Hygiene. Is marked other than "natural", or heme 23a or 28a-f show: raumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Nevar Married 210 Merried 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? ►XYas 2 No If Yas, Giva Yaar or Dates:	Army	Was Decede if Yas, speci 1 ☐ Yas 2				ecify Yes or No- Rican, etc.)	14. Rec Bla Specif	ce - Americ ck, Whita, by: Wh		
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altimore, Maryland	permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.	-	19a. informant's Name/Ralationship (Terry L. Fenningt			-				al Routa Numbe			/	
ore,	of Hea		20a. Mathod of Disposition		20b. Plece of Disp cemetary, cr	oosition (Nameratory or of	a of her ple	ece)		Data	20c. Location	- City or To	own, Stata	
Ĕ	Peg ment ant: H ury o		1 ☐ Burial 2 ☑ Stametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	<i>(y)</i>	Green 1					, 1998	Balt	imore	City	
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	cate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate	b. Du	a to (or as a cons	equance of):	1	26	щч					
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Viita		Be	25. Was casa rafarred to medical axaminar?					26. Plac	a of Deatt	h (Check only o	ne)			
		은	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpation	ent 3 DO	A Ot	har: 4□ N	ursing Ho	me 5 Aasid	lance 6 🗆 Ott	ner (Specif	y)	
Division of	Attending Ph or death. ector: After th by the funeral	on:	27. Mannar of Death 1 ☑ Natural 5 ☐ Panding	28a. Data of Injury (Month, Day Ye	28b. Tima injury		Bc. Inju		1	28d. Describe h	ow Injury occur	rred		
2	or Attending after death. Director: After in by the fune	icat	2 Accident invastigatio	e One Place of Injury	At home form	М		Yes 2	-	29f Location (6	Stroot and Alism	har or Dun	d Davida Mumba	
2	after Direct	Certification:	4 Homicida datarmined	28a. Place of Injury building, atc. (S	- At noma, tarm, s Specify)	treet, factory,	omca			City or Tow	n, Stata)	Der Or Hura	ii Routa Number	,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	edical C	29a. Cartifiar (Check only one)	ysician: To the best of miner: On the basis of axiand manner stated	amination and/or I	ith occurred a nvastigation,	t tha ti	ima, data ar opinion, das	nd place, a	and dua to tha d ed at tha tima, d	causa(s) and m data and placa,	annar as si and dua to	tated. o the causa(s)	
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			30. Nama and addrass of person who	complated causa of death	(Itam 23a) (Type	o, Print)	, h	a tor	AU	0 Bal7	more	nld.	21226	,
	Sta	te	31. Data filed (Month, Day, Year)	32 Registrar's			/	7/01	(- / - (- 1/			,	
	Registr	ar	JUN 0 3 1998	gra a sau	idson Bind	100								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) MAY 31, 1998 FOX 12.30 A.M. 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 7202 CHALKSTONE DR. #T-1 BALTIMORE N/A If Undar 1 Year 8. Data of Birth (Month, Day, Year) JAN. 6, 1915 if Under 24 Hrs. Birthplace (State or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 1□M XXF Months Days Hours 83 Yrs. MD 215-40-4821 Usual Rasidance of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7202 CHALKSTONE DR. #T-1 21208 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14 Raca - Amarican indian. Biack, White, etc. 1 Naver Married 2 Married 1 ☐ Yas 2 No 1 Yas 2√2 No Specify: WHITE 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 18b. Kind of Business/Industry Eiementary/Secondary (0-12) Collega (1-4or 5+) 12 WRITER POET LAUREATE 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) **JOSEPH** FINKEL DORA HAMBURGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 5718 UFFINGTON ROAD PATRICIA MacDONALD (DAUGHTER) 21209 BALTIMORE, MD 20b. Piace of Disposition (Nama of commatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Buriai 2 Cremation 3 Removal from State 6/2/98 BETH EL MEMORIAL PARK RANDALLSTOWN, MD 5 Othar (Specify) 4 Donation uneral Barvice Line 22. Nama and Address of Facility Sol Levinson & Bros., Inc. Part Enter the disease, or configurations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. 8900 Reisterstown Road Baltimore, MD 21208 Approximate Interval Between Onset and Death immediate Cause (Final disaasa or condition resulting in daath) ENDSTAGE CARDIOMYOPATHY 54EARS Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MULTIPLE CEREBRO VASCULAR 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? ACCIDENTS 1 Yas 2 No 1 Yes 2 No 26. Place of Death (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) Hospital: 1 inpatiant 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding

Examine physician and s the buriel-transit thet the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical USB signed by the e à The law requires Completed certificate has t or Attending Physician: director, Be To this funeral Certification: After death. ofter death Director: A d in by the f To the Hospital or within 24 hours eft To the Funeral Di completely filled in Medical

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

ir than "natural", or items 23a or

Pages 1 and 2 should be filed within 72 hours effer death nent of Health and Mentel Hygiene.

marked other

of Health of Item 27 is

Department of important: If it any injury or one.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

with the Maryland r 28a-f show

> 25. Was casa referred to medical axaminar? 1 Yas 2 No 27. Mannar of Death 1 DNaturai 1 Yas 2 No investigation 2 Accidant 3 Suicida 6 Could not ba datermined 281. Location (Straat and Numbar or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida

29a. Cartifian (Check only one) 29h. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd mannar stated.

29c. Licansa number P38950 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

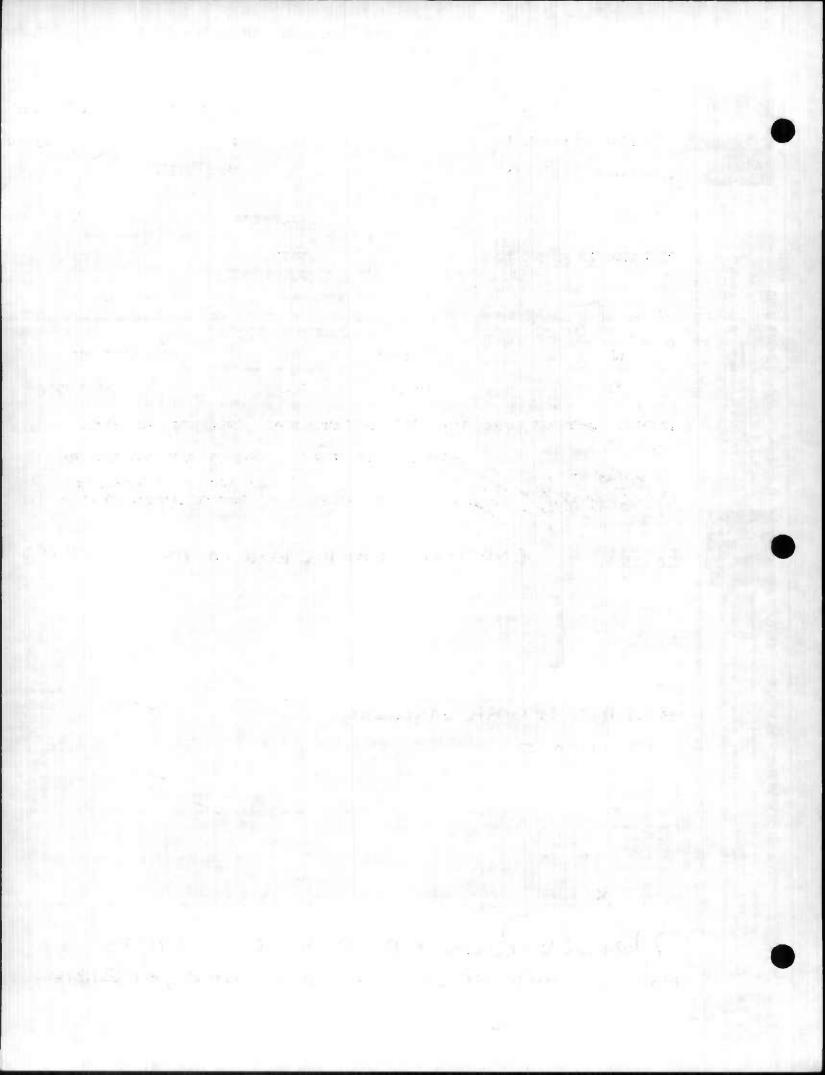
MANUEZ PAMOS, MD 6800 YORK PD, BATTI MORE, MD 21212

State Registrar 31. Date filed (Month, Day, Year)

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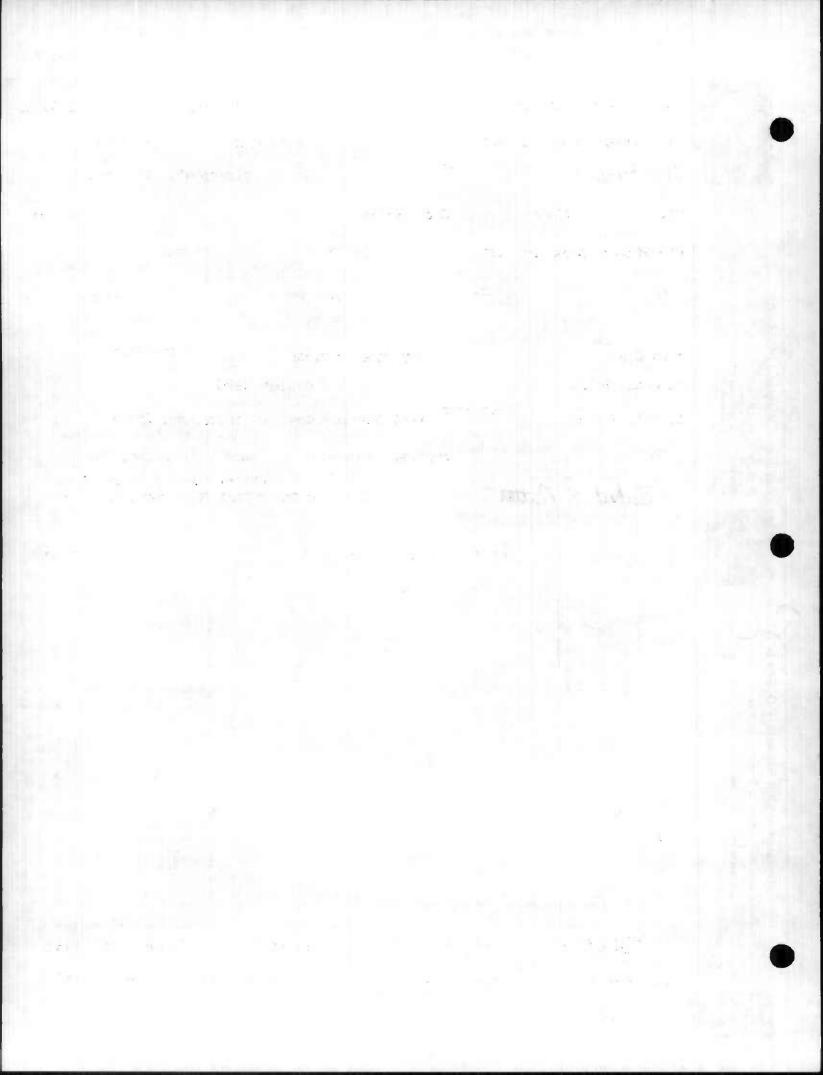
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 7 89 Certificate of Death Reg. No. 2. Detect Death 3. Time of Death

				Certifica	ate of	Death		Reg. No.		1105
	1. Decedent's Name (First, Middle, Last)					2. Dete of D	eeth Dey	Yeer	3. Time of Deeth
Physician /Medical	Leola Virginia Fie	elds					May 31		1001	12:20a.m.
Examiner	4a Fecility Neme (If not institution, give	street and number)				4b. City, Town	n, or Location of Dee	th 4c. County	of Deeth	
	815 Winters Lane A	pt. 221				Catons	ville	Balt	timor	e
Funeral Director	5. Social Security Number 219-30-2186 Usuel Residence of Decedent	X 7. Age ((In yrs. last bin	Yrs. If Un Mont	der 1 Year hs Deys		Min. (Month, D		9. Birthp	plece (State or Foreign htry)
and w	10a. Stete 10b. County	1	IOc. City, Town	n or Location			-		1	Od. Inside City Limits
a-f aho	Md. Baltimo	re	Caton	sville						1 ☐ Yes 3 ☐ No
free death with the Mai r thems 23s or 28s-f s free must be notified funeral Director	10e. Street end Number 815 Winters Lane A	pt. 221			Zip Code 1228			10g. Citizen of V	Vhet Cour	ntry?
urs a	11. Merital Status 13. Wever Married 2 Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:			s 2/2/No		n? (Specify Yes or N Puerto Rican, etc.)	Bied	a - Americ k, White,	
72 h	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a.	Decedent's U (Give kind of	suel Occu work done	petion during most o	of working	16b. Kind of Bu	usiness/In	dustry
2 P ()	Elementery/Secondery (0-12) 12th Grade	College (1-4or 5+)		y Care		ider		Self-Emp		ed
dout Hair H	17. Fether's Name (First, Middle, Last) Granger Fields						s Neme <i>(First, Middi</i> Ragland	e, Ma <i>iden Suma</i> m	(e)	
d 2 should but and Mente	19e. Intorment's Neme/Relationship (7)	vne Printh	19b	Melling Addr	ess (Stree		or Rural Route Num	ber. City or Town.	State, Ziu	Code)
127 T	Cynthia Hinton	Daught	er 11				Baltimore			
8 5 2 2	20e. Method of Disposition Suriel 2 Cremation 3 4 Donetion 5 Other (Specify,	Removel trom State		Disposition (in property) of the company of the com			June 4	20c. Location - Woodlawr		
permit. Page: Department of important: If i any Injury or 00000.	21. Signeture of Funeral Service Licens However & M					ess of Fecility	Nutter Fi			
N	23e. Pert1. Enter the disease, or comp shock, or heert teilure. List only o	000	ne deeth. Do						1100	Approximete Intervel Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Respir								Onset end Deeth
	resuming in deeth)		ue to (or es e		ot):					
n and instransit		0	rodern		-4)				i	yeniss
Cal De Du	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury the initial end events resulting in deeth) Last	c	ue to (or es e due to (or es e d							
death certifical e attending phy ed for use as th	L	d							1	
death cert e attendin od for use	Pert II. Other eignificant conditions co	ntributing to death but	not resulting in	n the underlyin	ng cause g	iven in Pert I.	23b. Die	tobacco use co	ntribute t	o the cause of death
uries that the death certing to signed by the attending tid be detached for use a day by signey.							10	Yee 2 No	3 ☐ Pro	bably 4 N Unknow
pear pear should should be ete							24e. We per	s en eutopsy formed?	81	Vere autopsy tindings veileble prior to ompletion of cause death?
yaicien: The law s certificate has director, page 2 To Be Compl							1	Yes 2 No	1	□Yes 2 No
	25. Wes case referred to medical					26. Piece o	of Deeth (Check only	one)	1	
Physicien: T this certificat ral director, pr	examiner? 1 ☐ Yes 2 💢 No	Hospitel: 1 Inpatient	2 □ ER/Oι	utpetient 3	DOA O	ther: 4 🗆 Nurs	sing Home 5 ARe	sidenca 6 Oth	er (Speci	fy)
e ffe Co	27. Menner of Death 1 Neturel 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Dey	Year) 28b.	Time of njury M	28c. inju Wo	iryet ork?]Yes 2 □ No		how injury occur	red	
tal or Attanding P is after death. al Director: After t led in by the funers Certification:	3 Sulcide 6 Could not be determined	28e. Pleca ot Injury building, etc.	y - At home, fa (Specity)	ırm, street, fed	ctory, office			(Street and Numb own, Stete)	er or Aur	al Route Number,
n 24 hospi n 24 hour ne Funer pletely fill	29e. Certifier (Check only one) 2 Medicat Exami	eician: To the best of lner: On the basis of e end menner stete	xeminetion en	deeth occur dor investigat	red at the t tion, in my	ime, date end opinion, deeth	plece, end due to the cocurred et the time	e cause(s) and me e, date end place,	end due t	steted. to the cause(s)
withir comp	29b. Signeture and title of certifier				29c. Licer	ise number		29d. Dete signe	d (Month,	Day, Year)
(4	Refusition	M.	D.		P	11698	3	June	02	, 1998
10	30. Name and address of person who c	900	Cato	no	AVE	_	ALTIMOR	E , m)	D	21229
State Registrar	31. Dete tiled (Month, Day, Year) JUN 0 3 1998	38 Registrat	Signaturen	dable						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Yesr 98 458 James Claybert Faircloth 30 4b. City, Town, or Location of Death 4a Fscility Neme (Il not institution, give street and number) 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Undar 1 Yaar | If Under 24 Hrs. Sax M 2 F 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) Months Days Hours Min Yrs. 69 160-24-0783 1928 North Carolina 13, Usual Rasidence of Dacedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Prince Georges New Carrollton 10e Street and Number 10f. Zin Coda 10g. Citizen of What Country? 8006 Powhatan Street 20784 USA 12. Was Dacedant Evar In U,S. Armed Forcas? 1∆ Yas 2 □ No If Yas, Giva Yaar or Datas: WW∏ I Was Decedant of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian. 11. Maritel Status Black, Whita, atc. 1 Nevar Marriad 2 Married White 1 Yas 2 No Specify: 3\OWidowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Elementery/Secondery (0-12) Collega (1-4or 5+) 10 **Plumber** Plumbing 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Mossette Lee Faircloth Macy Eunice Harrell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Terri Mae Lough - Daughter 8330 Sunset Drive, Ellicott City, MD 21043 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Buriat 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MD Veterans Cemetery 06/05 Crownsville, MD 21. Signatura of Funeral Service Licensa 22. Nama and Addrass of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter tha diseasa, or complications that ceusad tha death. Do not antar tha mode of dying, such as cardiac or respiretory arrest, had been conset and Death. Immediete Ceuse (Finel diseesa or condition rasulting in daath) Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last sem 23b. Did tobsccq use contributs to the csues of death? 10 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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MD

Funeral

Director

from 27 is marked other than "naturel", or itema 23a or 28a-f show other treumetic event, the Modical Examiner must be notified at

2 should be filed within 72 hours efter deeth nend Mental Hygiene.

permit. Peges 1 end 2. Department of Health el Important: If Item 27 is

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any Injury

altimore, Maryland 21215-0020

Box 68760.

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Division of Vital Records,

the Marylenc

g physicien and es the burief-trensit esn signed by t certificate

Examiner Physician/Medical þ Completed Be To uneral

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24b. Wara sutopsy findings aveileble prior to 24a. Wes an sutopsy performad? completion of cause of dasth?

1 Yas 2 100 1 Yas 2 No 26. Pleca of Daeth (Chack only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatient 3 DOA 2 ER/Outpatient 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Maeth 28b. Time of 28c. Injury at Work? 1 DNatural 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accidant 28f. Location (Street and Number or Rurel Route Number, City or Town, Steta) 6 Could not be daterminad 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homicida

29a. Certifie (Check only one) 1 Destifying Physicisn: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end mennar as stated.

2 Medical Examinar: On the basis of examination and/or invastigetion, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end menner stated.

29c. Licansa number

29b. Signatura and titla of certifian

30. Name and sodiess of person who complated cause of deeth (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

10

After or Attending

r deeth.

24 hours after deet Funeral Director:

within 2

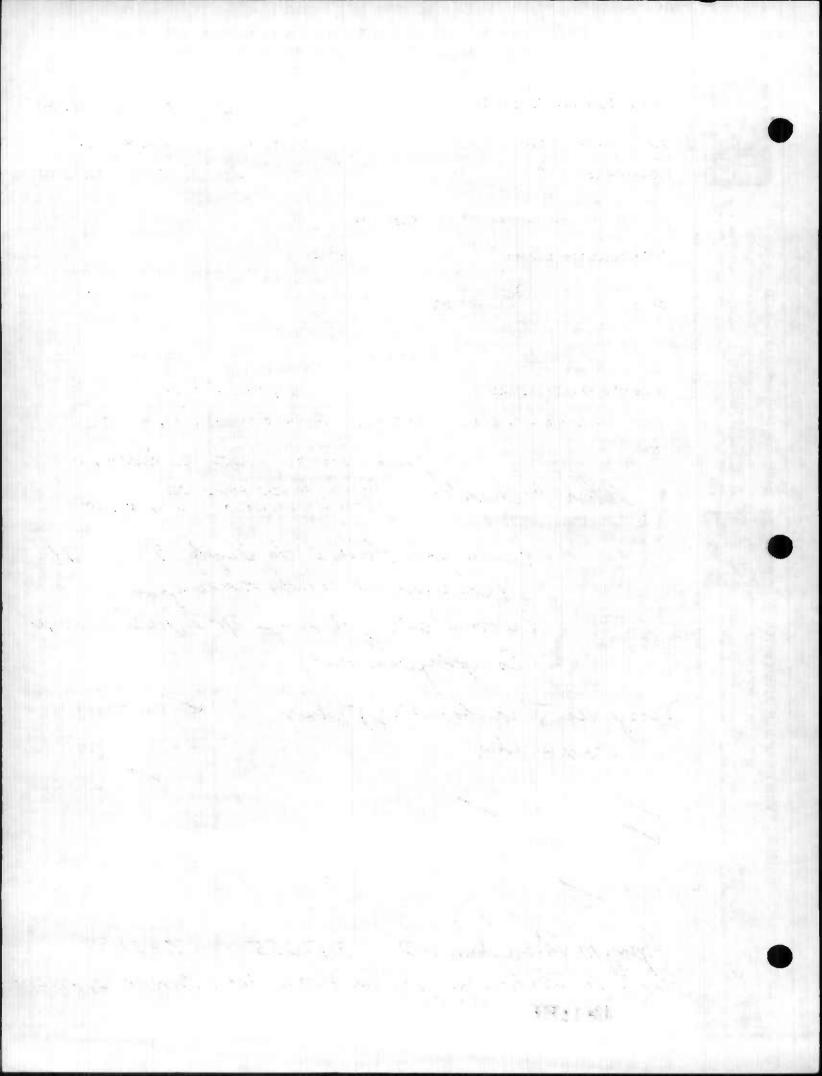
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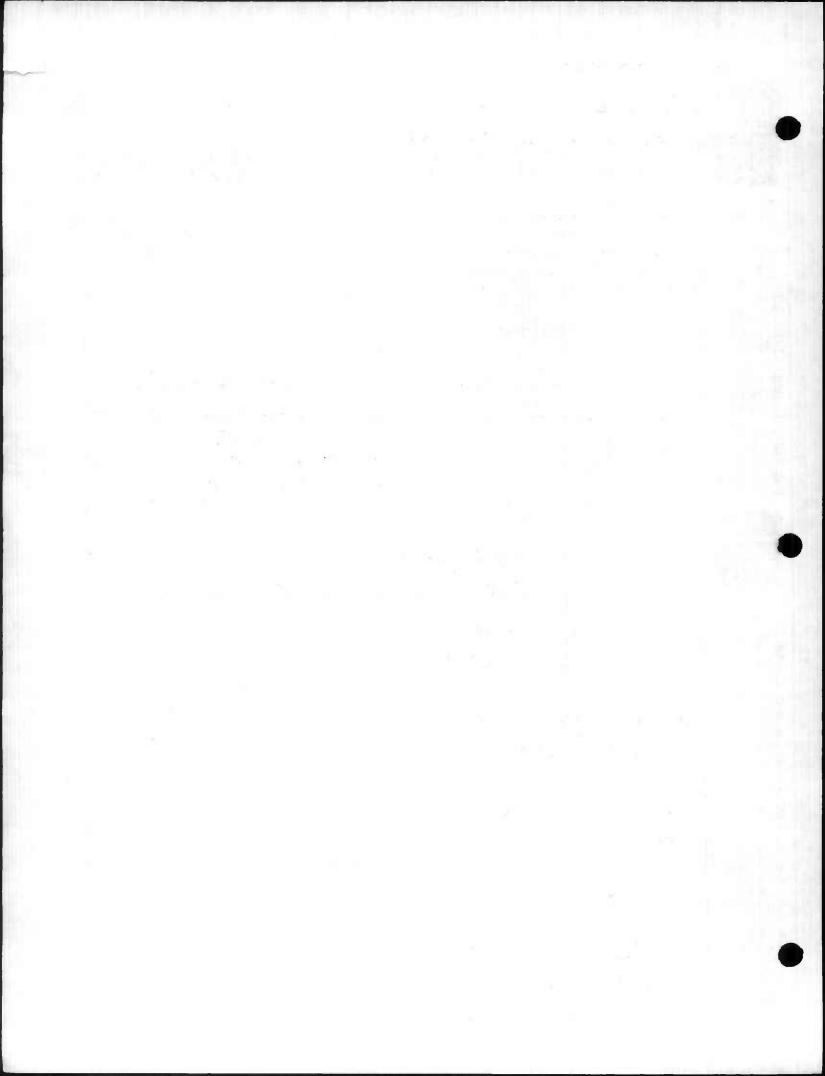
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104 Forbes Street Annapolis, mol 2140) KichARNSIN.



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IIt	em.	20b per FH Film G760 6	-3-98 rja		Certificate of		2. Dete of De	Reg. No.	0 1	7 191
Physic		Dorcull L. Fitz	patric K	- 1			Month	Dey	Year 98	3. Time of Deeth 22:30
/Medi Examir		4e. Facility Name (If not institution, gir	/e street end number)	/	-10	4b. City, Town, or Lo		h _4c. County		
		Mt. Washington	Pechadr	c Hosp	, tal	Boltim	R		n/a	
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and w		Usual Residence of Decedent 10e. Stete 10b. County		10c. City, Town	or Location				100	d. Inside City Limits
Mary	tor	Md. Anne Aru	ndel Co.	Pasade	ena					1 ☐ Yes 27 No
th with the 23e or 28	al Director	10e. Street end Number 7872 Newfreeto	wn Road		10f. Zip Code 21	122		10g. Citizen of US		y?
72 hours after deeth with the Maryland 72 hours after deeth with the Maryland natural', or items 23s or 28s-1 show likes Examiner must be notified at	by Funeral	11. Marital Status 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 1 Yes, Give Yeer or Dates:		13. Was Decedent of In If Yes, specify Cub. 1 ☐ Yes 2 🛣 No		ecify Yes or No Rican, etc.)	Specify	ce - Americe ck, White, et y: blac	c.
within she.	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12)	ducation ede completed) College (1-4or 9	5+)	Decedent's Usuel Occup Give kind of work done ife. DO NOT use retire cudent	eation during most of worki d)	ing	16b. Kind of B		stry
Hygi other	Be Co	17. Fether's Neme (First, Middle, Last)			18. Mother's Neme	(First, Middle	, Meiden Sumen	ne)	
should be and Mental I marked of umatic eve	To B	Darryll L. Fitzp	atrick, Si	r.(Father	-)	Sherri	L. Nole	es (Moth	er)	
e, Inda yidiid 1 and 2 should be filk Health and Mental Hy em 27 is marked oth ther treumatic event		Darryll L. Fitz			Meiling Address (Street 372 Newfree	end Number or Rura town Road	Pasade	ena, Md.	Stete, Zip C	Code) 2
Pages nent of int: If it		20a. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Speci		cemetery,	Disposition (Name of cremetory or other please) Chapel Ceme		une 5 998	20c. Location -		
permit. Pag Department Important: I any Injury o		21. Signature of Funeral Servica Lica	nsee &		22. Neme end Addre McCully-P 3204 Moun	ss of Facility Olyniak F tain Road	uneral Pasade	Home ena, Md.	2112	2
Physician /Medicai Examiner	ər	shock, or heart feiture. List only immediate Ceuse (Finel disease or condition resulting in death)	e. Hyd	Due to (or es e co	Rus	24				ntervel Between Onset end Deeth
The law requires that the death certificate be executed the best been signed by the ettending physician and page 2 should be deteched for use as the buriel-frensit	an/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that intilleted events resulting in death) Lest	o. Trace	Due to for es e con Due to for es e con CP	7	hen	_ (re	wised	4/9	8)
the ett	Physician/N	Pert II. Other significent conditions	ontributing to death b	ut not resulting In t	he underlying ceuse giv	ren in Pert I.	23b. Did	tobacco usa co	ntribute to t	he cause of death!
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							1 🗆	Yes 2 No	10	Yes 2 No
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To the Hospital or Attending I within 24 hours efter deeling To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	e 28e. Plece of Inj building, etc	ury - At home, farm c. (Specify)	n, street, fectory, offica	- 1	281. Location (City or To	Street end Numb wn, Stete)	per or Rural I	Route Number,
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Withi To th	Σ	296. Signature and Ittle of certifier	0		29c. Licens			29d. Date signe		
		> X felice	by, M	0.	152	138		6/1	198	
		30. Name and appress of person who Parry (Adam)	completed cause of d		ype, Print) Fell St.	Baltin	ore	MD		
Sta Registr		31. Dete filed (Month, Day, Yeer)	32 Registr	ar's Signature	1.00		1			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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Certificate of Death	Reg. No.	20	1/1	
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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryler Inportament of Health end Mental Hygiene. Inportant: If tham 27 is marked other than "natural", or itsms 23a or 23a-f show any injury or other traumatic event, the Medical Examinar must be notified an other.

Baltimore, Maryland 21215-0020

Physician /Medicai Examiner

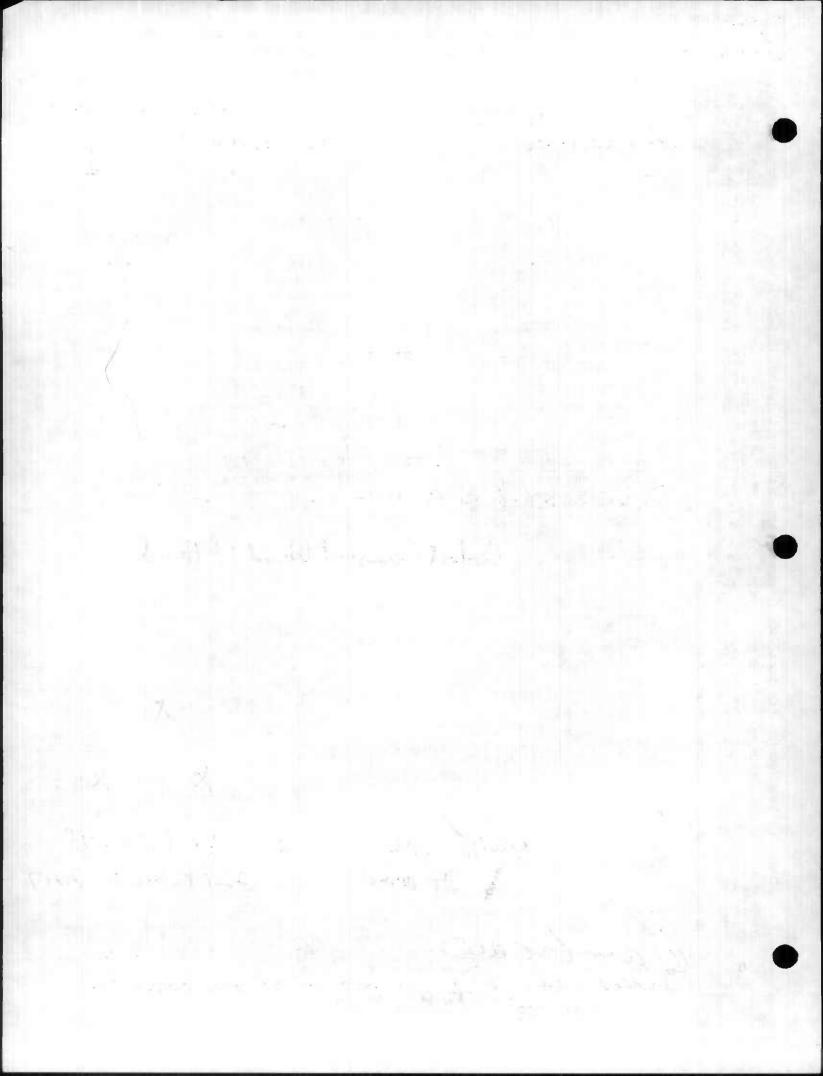
To the Hospital or Attending Physician: The lew requires that the death certificate be assocuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

			Ce	rtifica	te or i	Deall			Reg. No.			
1. Decedent's Name (First, Middle, Last	t)							2. Dete of De Month	ath Dey	,	Yeer	3. Time of Deat
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4a Facility Neme (If not institution, give	street and numb	er)			4	b. City, To	own, or Lo	ocation of Deet	4c. (County of	Death	
2301 PULASKI STRE	EII'				Е	BALTI	MORE	CITY		1	N/A	
Sociel Security Number 6. Se		Age (In yrs. I	lest birthdey)) If Unde	or 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, De	th Vear)	1	9. Birthpl	ece (Stete or Fore
216-08-7617	ØM 2□F	13	Yrs.	Telorario	Days	110015	14/11/1	1/19/8				YLAND
Usual Residence of Decedent		1.0 0:										
10a. Stete 10b. County		10c. City	, Town or Lo	ocation							10	d. Inside City Lin
MD N/A	A			ВА	LTIM	10RE						1) Yes 2
10e. Street end Number				10f. Zi	ip Code				10g. Citiz	en of Wh	nat Count	ry?
2301 PULASKI ST	г.				2 1	217				U.	.S.	
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21. Signature of Funeral Service Licens				2. Name a				IZABET				
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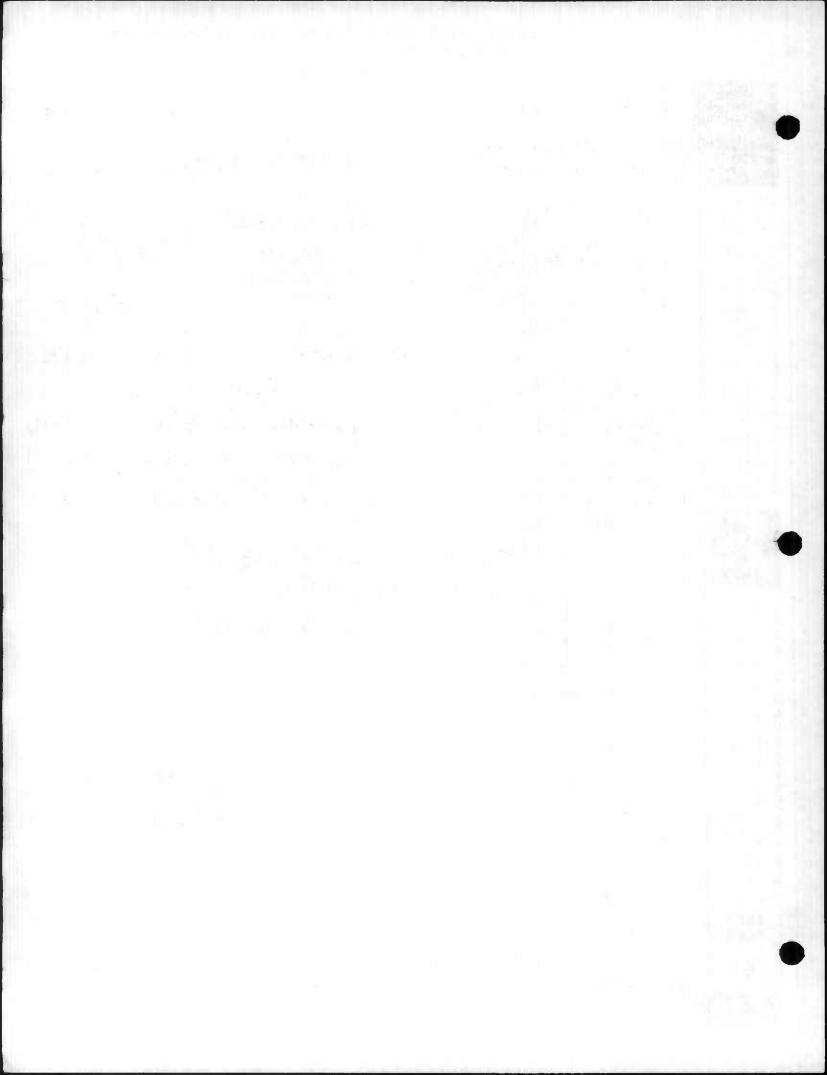
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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faryland 21215-0020 2 should be filed within 72 hours after death with the Manyland and Mental hygiene. Is merked other than "natural", or Hema 23a or 28a-f show raumatic event, the Medical Examinations the notified at	Funeral	11. Marital Status		S 13 Was Decedent o	f Hispanic Origin? (S)	posify Voc or No	14 Page - 4	American Indian,
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Baltimore, Maryland 21215-002 permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Phyllene. Important: If tem 27 is merked other than "natural; any injury or other traumatic event, the Medical Example.		21. Signature of Funeral Service Lice	nsee	22. Name and Add	Irass of Facility	61 Ost	11, Pc	1
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Vision of Vita Attending Physician: rf deeth. ettor: After this certific by the funeral director,	၉	1 ☐ Yes 2 ☐ No		ER/Outpatient 3 DOA	Other: 4 Nursing H	ome 5 XRasidenc	e 8 DOther (5	Specify)
Ing Ph Ing Ph After th funeral	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. In	jury at	28d. Describe how	Injury occurred	
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Division of Vital Records, or Attanding Physician: The law requires the after death. Birector: After this certificate has been signed in by the funeral director, page 2 should be come.	Certification:	4 ☐ Homicide determined	building, etc. (Specify	<i>'</i>)		City or Town, S		
Division To the Hospital or Attandi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fo	ŭ							
osp hor hy fi	cai	29a. Certifier t Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my know	wledge, death occurred at tha	tima, data and place,	and due to tha caus	e(s) and manne	r as stated.
the H hin 24 the Fi	edicai	one)	nfnar: On the basis of examinat and mannar stated.	ion and/or investigation, in my	opinion, daath occui	rad at the time, date	and place, and	due to the cause(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 91 Items: 10b,c,d per F.H. G-760 6/3/98 reb Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death QYear Month Bonnie A. Ford 4:50 AM 5 21 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death Baltimore University of Maryland Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 1□M 2XF Months Days 51 217-46-3100 Yrs. Maryland 12-22-46 Usual Residence of Decedent 10b. County BALTIMORE 10d. Inside City Limits 10c. City, Town or Location CATON MANOR Yes XX No Baltimore City Baltimore 10e. Street and Number 10f. Zlp Code 10g. Citizan of What Country? Harford USA 21207 6016 Ave 12. Was Decedent Evar in U,S. Armed Forces? Was Decedenl of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marilal Status Black, White, etc. 1 ☐ Yes ② No If Yas, Giva Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yas 2X No Specify: Specify: White 3 ☐ Widowad 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Sacondary (0-12) College (1-4or 5+) 12th Housewife Domestic 18. Mothar's Nama (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Mcfail Otis Constance Paine 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mary Patricia Miller / Sister 824 Stamford Rd. Baltimore, Maryland 21229 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 5/21/98 Baltimore, Maryland 21. Signature of Funeral Service Coense 22. Name and Address of Facility David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore, Maryland 21229 one cause on each line. Approximate Approxi Approximata Interval Between Onsel and Death Immediata Cause (Final disease or condition resulting in death) Sequantially list conditions, it sny, laading to Immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco uss contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medicel examinar? 26. Placa of Death (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Sinpatient 2 □ ER/Outpatient 3 □ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Director

Funeral

py

Completed

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours eftar deeth with the Marylan Department of Haeith and Mentel Hyglena. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Event has mark to not reason.

Baltimore, Maryland 21215-0020

Examiner physicien and the burial-transit Physician/Medical ed by the detached signed by to þ should t Completed certificate has t Be Certification: To

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

director, this funeral After daath. Director: /

27. Mannar of Death

Natural

2 Accident

3 Suicida

29a. Certifian

4 Homicida

31. Date filed (Month, Day, JUN 2

5 Pending Investigation

the Funeral Di the Funeral Di To the To the To the

State Registrar

Medical

6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number

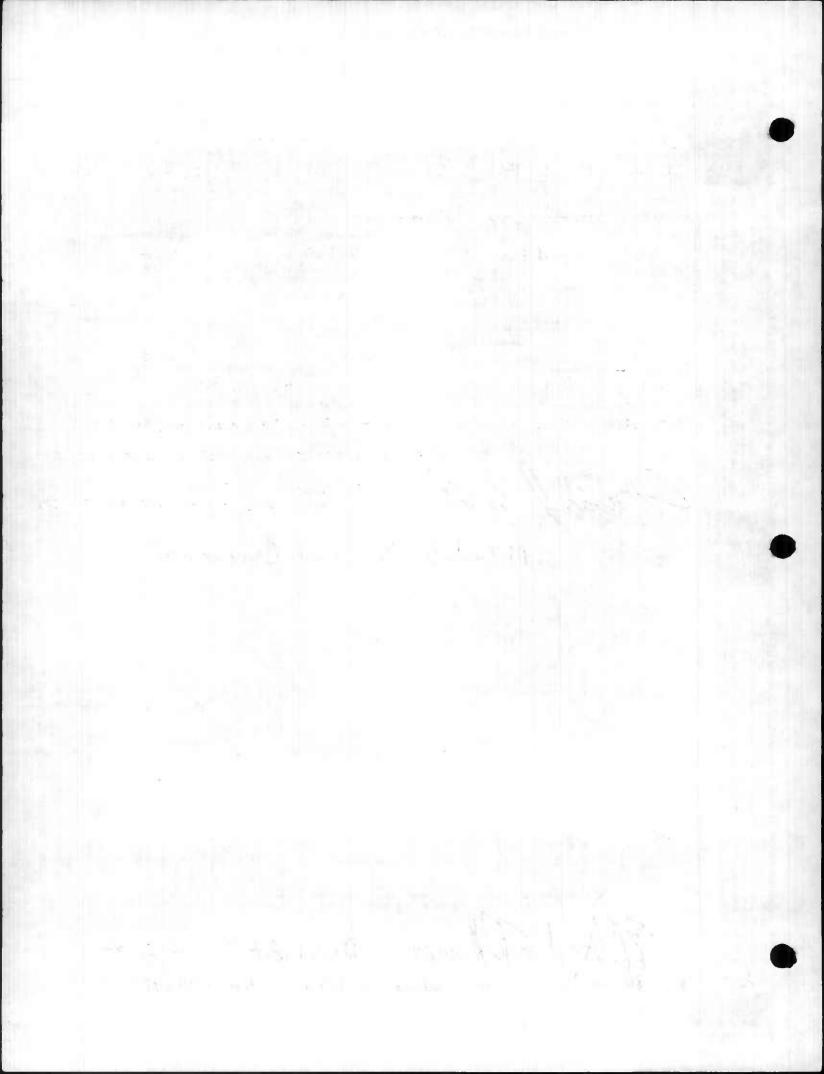
ot oaath (Itam 23a) (Type, Print) REMY BLANCHAZITT MO, ONS

419 W. Relwood, BaltimoreMD 21201 Sinte 110

28d. Describe how Injury occurred

Registrar's Signature who Davidson-Randelle

28a. Date of Injury (Month, Day Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day CREORCRE Month Year **Physician** 1St 09:30AY YRVS JUNE 1998 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not Institution, give street end number) 4c. County of Death Examiner N/A TAL BALTIMORE HOSPI CENTER HARBOR If Under 24 Hrs. If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 6. Sex **Funeral X**□ M 2□ F Months Deys Hours 63 215-30-2823 Dec. 22, 1934 Pennsylvania Director Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State r than "natural", or items 23s or 28s-f show the Medical Examples must be notified at 1 ☐ Yes 2 X No Dundalk Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 7836 St. Claire Lane United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: if item 27 is marked other than "natural", or ite ity or other traumatic event, its Medical Earth is ny or other traumatic event, its Medical Earth is 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Journey Lineman Journeywork 12 Years 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jean Bonaseif 10 Daniel George 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Mrs. Joyce George/Wife 21222 7836 St. Claire Lane Dundalk, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of important: If any injury or once. 6/3/1998 Towson, Maryland Hilltop Service Corp. 21. Signature of Funeral Sequide License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, In c. 23a. Part 1. Enter the disease, or complications that code of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately 10 to 10 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical IUNG CANCER · METASTATIC 11 MONTHS Examiner Due to (or as a consequence of): Physician/Medical Examir Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 30 Probably 4 Unknown THROMBOCYTOPENTA à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed ANAEMIA completion of cause of death? 9080 1 Yes 2 No 1 Tyes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) Be Hospital: 1 I Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Yes 2 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only

Division after b 24 hours Funeral To the within 2 To the

P.O. Box

of Vital Records,

The

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certificate

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Athor

with the Maryland

death

altimore, Maryland 21215-0020

State Registrar

PTYUSH 31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

MD.

29c. License number AS-2441614-A9 JUNE

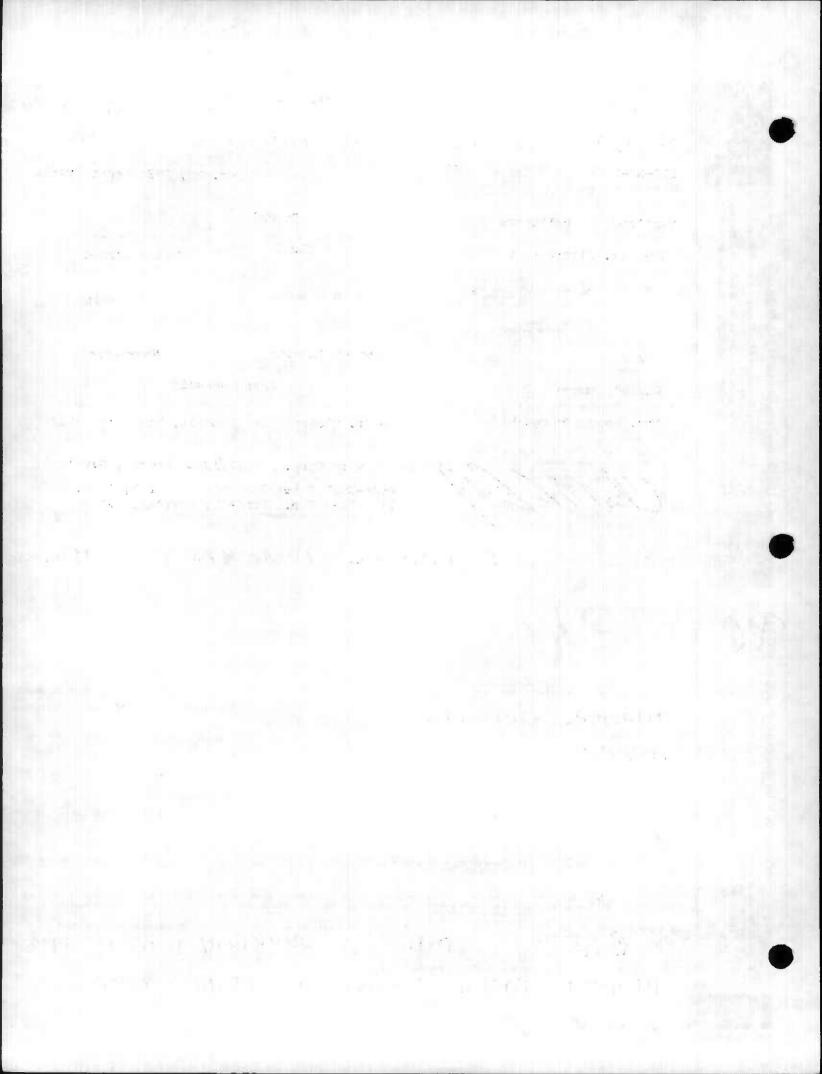
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

PATEL. 32. Registrar's Signature

HARBOR HUSPITAL CENTER

Aulia Varidson-Randall JUN 0 3 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Date of Death Month Vaai Robertetta Geyer 4a. Fecility Nama (If not institution, giva street and number) 1998 8:19 pm June 4b. City, Town, or Location of Death 4c. County of Deeth Center Boiltmore If Under 1 Year If Under 24 Hrs. 8. Date N/A Bayview Johns Hookins Medical 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Steta or Foreign Country) 1 □ M 2 1 F Months Days Hours Min. Yrs. 67 218-26-7557 Virginia April 9,1931 Usual Rasidance of Decedant 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 20 No Dundalk Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 21222 United States 35 Lombardy Drive 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. 11. Maritat Status 1 Naver Married 2 Married 1 ☐ Yas 2 ☐ No Specify: White 3 Widowed 4 □ Divorced 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working iife. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collaga (1-4or 5+) 2 Years Social Security Clerical 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Sadie Miller Elmer Drohan 19a. tnformant's Name/Reletionship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Robert L. Geyer Son 35 Lombardy Drive Dundalk, Maryland 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 Donation Holly Hill Mem. Gdns. 6/6/98 5 Othar (Spacify) Middle River, MD 21. Signature of aval Servish License 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD Enter the disaasa, or complications that caused the death. Do not anter tha moda of dying, such as cardiac or respiretory arrest, or haart failura. List only ona causa on aach lina. Approximate Intarval Ratween Onset end Daeth tmmediete Ceusa (Finat . Pseudomonas infection disaese or condition rasulting in daath) 7 days Dua to (or es e consequance of): Veutropenia Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Chemothenapy Due to (or as a consequence of): Lymphoma Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Anexic brain injury 24a. Was an autopsy performed? 24b. Wara autopsy findings eveilable prior to Cholecystins completion of cause of deeth? 2 - No 25. Was casa rafarrad to medical 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 1X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daath 28a. Deta of Injury (Month, Day Year) 28b, Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accidant 5 Panding

Box 687 The law requires that the death cert Division of Vital Records, P.O. signed by d this certificate has After Attending

Completed by Be (2

edicai

3 Suicide

29a. Certifier

4 Homicida

29b. Signatura end titla of cartifiar

Physician/Medical Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral Director

by

Completed

Be

7 is marked other than "natural", or items 23s or 25s-f show traumatic event, the Medical Examinatment be notified at

and Mental Hygiene.

nt of Health a if Itam 27 is or other tra

permit. Page Department of Important: If any Injury or once.

Physician /Medical

Examiner

Pages 1 and 2 should be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

f or Attend after death Director; A A u To the Hospital of Wilhin 24 hours a To the Funeral D

State Registrar

JUN 0 3 1998

investigation

8 Could not be determined

JHBMC

4940

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

1 Cartifying Phyaiclan: To the best of my knowladga, death occurred et the tima, date and placa, and dua to tha cause(s) end menner es stated.

2 Medicat Examinar: On tha basis of exemination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) end mannar statad. 29c. Licansa number

21224

1 ☐ Yes 2 ☐ No

Balt, MD

96125

29d. Data signed (Month, Day, Year)

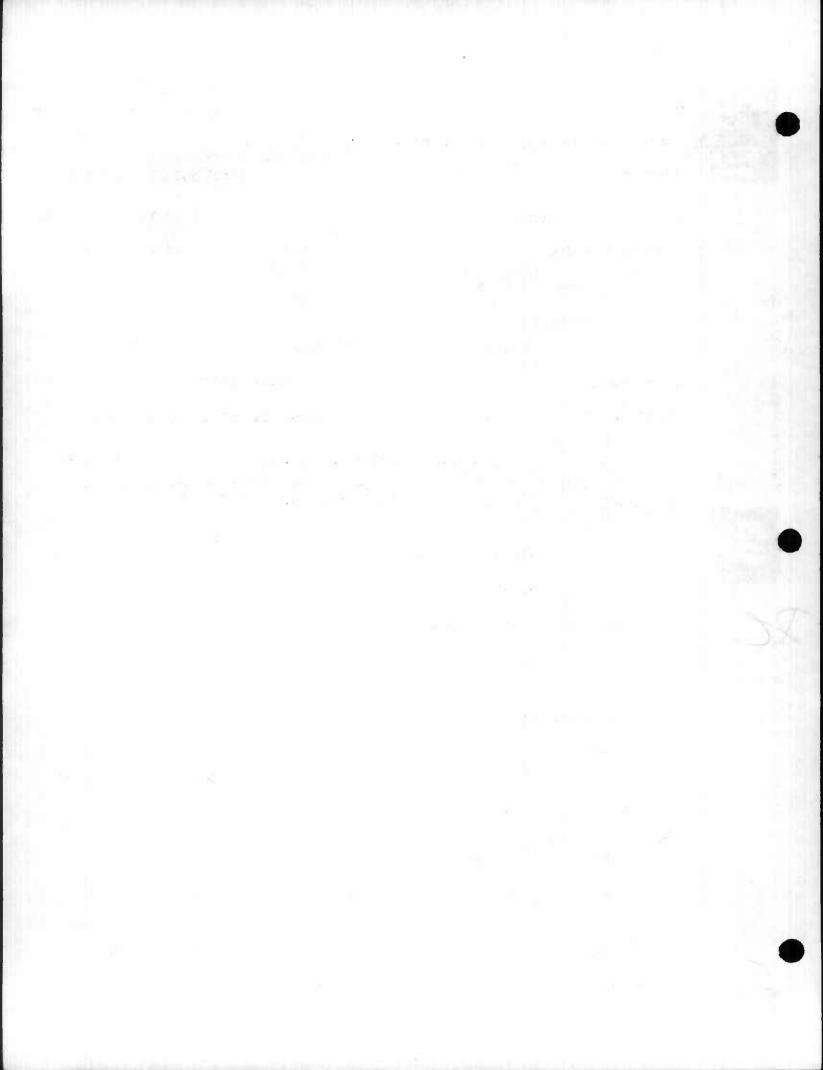
June 1, 1998

28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta)

30. Nama and eddress of person who completed causa of daath (ttam 23e) (Type, Print)

Jean Hu, MD Eastern Ave 31. Data fitad (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

Months

DAVID GRIFFITH

State of Maryland / Department of Health and Mental Hygiene Items: 23 part I,27,28a-f per MEO G-760 6/3/98 ertificate of Death

2 Date of Death

17,1998

Physician	
/Medical	
Examiner	

David C. Griffith 4a Facility Name (If not institution, give street end number)

1∭ M 2□ F

Chester

Month MAY

3. Time of Death 11:06A.M

400 KEY HWY

INNER HARBOR MARINA

4b. City, Town, or Location of Death BALTIMORE

If Under 1 Yeer | If Under 24 Hrs.

Hours

4c. County of Death Baltimore

Funeral Director

with the Maryland

2 should be filed within 72 hours after a and Mental Hygiene.

Baltimore, Maryland 21215-0020

410

10a. State 10b. County

1 Decedent's Name (First Middle Last)

10c. City, Town or Location

Yrs.

7. Age (In yrs. last birthday)

37

8. Dete of Birth (Month, Dey, Year)
Jan. 27, 1961

 Birthplece (State or Foreign Country) Wilmington, DE

Usual Residence of Decedent nem 27 is marked other than "natural", or items 23s or 28s-1 ehow other traumstic event, the Medical Examiner must be notified at

Director

Funeral

py

Completed

2

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

edical

Lincoln University

10d. Inside City Limits 1 Yes 2 No

10e Street and Number

5. Sociel Security Number

181-52-7635

19352

10f. Zip Code

Days

10g. Citizen of What Country? USA

103 Lewisville Rd.

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

Bieck, White, etc. Specify: White

14. Rece - American Indien,

15. Decedent's Education (Specify only highest grede completed) Eiementary/Secondary (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

contractor

construction 18. Mother's Name (First, Middle, Meiden Surneme)

17. Fether's Name (First, Middle, Last) John Griffith

Geraldine Szymanski 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

19e. Informant's Name/Relationship (Type, Print)

103 Lewisville Rd., Lincoln University, PA 19352 20c. Location - City or Town, State

Gabriella Griffith 20e. Method of Disposition

1 ☐ Burial 2X Cremetion 3 X Removei from State

20b. Pieca of Disposition (Name of cametery, cremetory or other plece) R. A. Ferris & Co.

5/26

West Chester, PA

4 Donation S ☐ Other (Specify) Signature of Fundrel Service Licenses

Ussell. 30 L

ntt. Piter the disease, or complications that chusad the lock, or heart failure. List only one cause on each line

22. Name and Address of Fecility

Kuzo & Gofus Funeral Home, Inc.

Kennett Square, PA used the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Physician /Medical Examiner

signed by the attending physician end d be detached for use as the burial-transit

peen

this certificate has

After

death.

or Attend after death Director:

To the Hospital within 24 hours a To the Funeral C

0

funeral

certificate be exec Box 68760

P.O.

Division of Vital Records,

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Immediate Cause (Final disease or condition resulting in deeth)

COCAINE INTOXICATION

Due to (or es e consequence of):

Due to (or es e consequence of)

Due to (or es e consequença of):

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

3 Probably 4 Unknown

24e. Wes en eutopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death?

Approximete Interval Between Onset end Deeth

2 No

25. Was case referred to medical exeminer? 1 Yes 2 No

29b. Signature and title of certifier

27. Manner of Death

1 Neturel

2 Accident

3 Suicide

4 - Homicide

5 Pending investigation

6XX Could not be determined

28a. Date of Injury (Month, Dev Year) found 5/16/98

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of founding 9:30

Other: 4 Nursing Home 5 Residence 6 Other (Specify) BOAT 28c. Injury et Work? 1 Tyes 2(X) No

28d. Describe how injury occurred

Unknown

26. Place of Death (Check only one)

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State) 400 Key Highway Baltimore, Maryland

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and merimer as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and merimer stated. Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and piaca, and due to the cause(s) and menner as stated. 29e. Certifier (Check only

29c. License number

O.C.M.E.

29d. Dete signed (Month, Day, Year)

MAY 18,1998

30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)

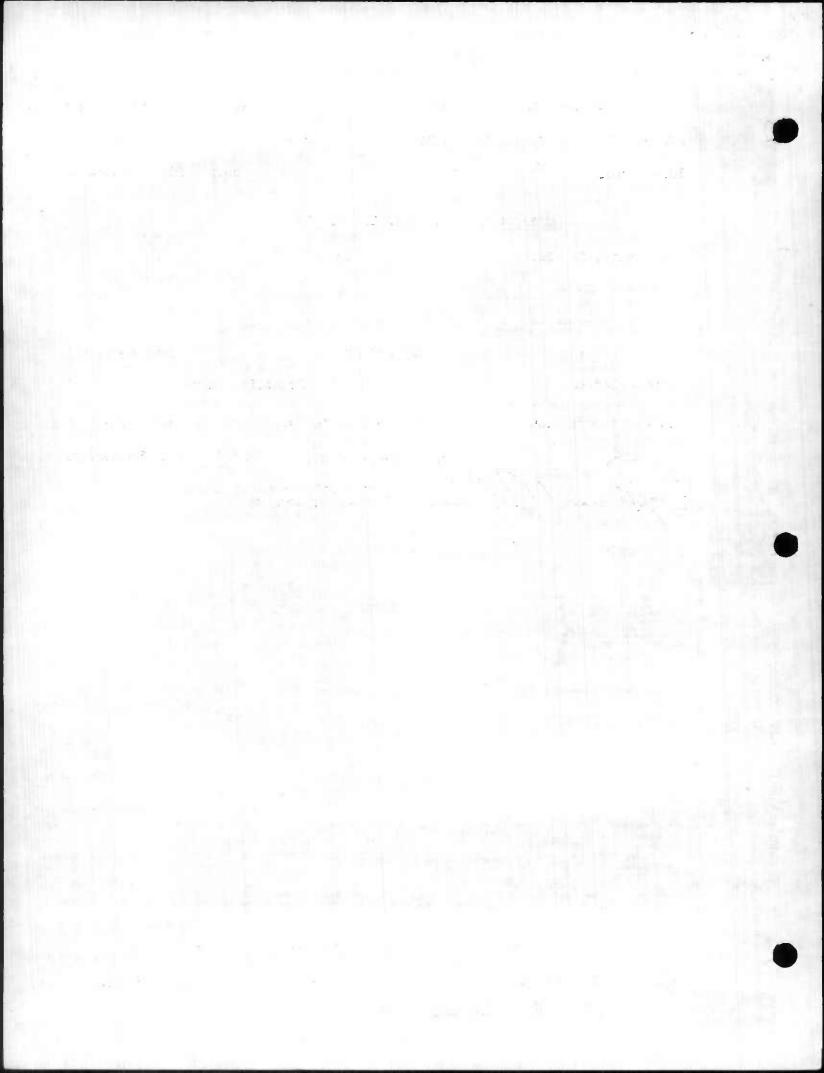
Hospital:

R wwer HEWIN 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

MAY 21 1998 32. Registrer's Signature

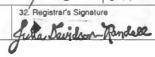


Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 G760 6-3-98 rja Certificate of Death Reg. No. 2 Date of Death

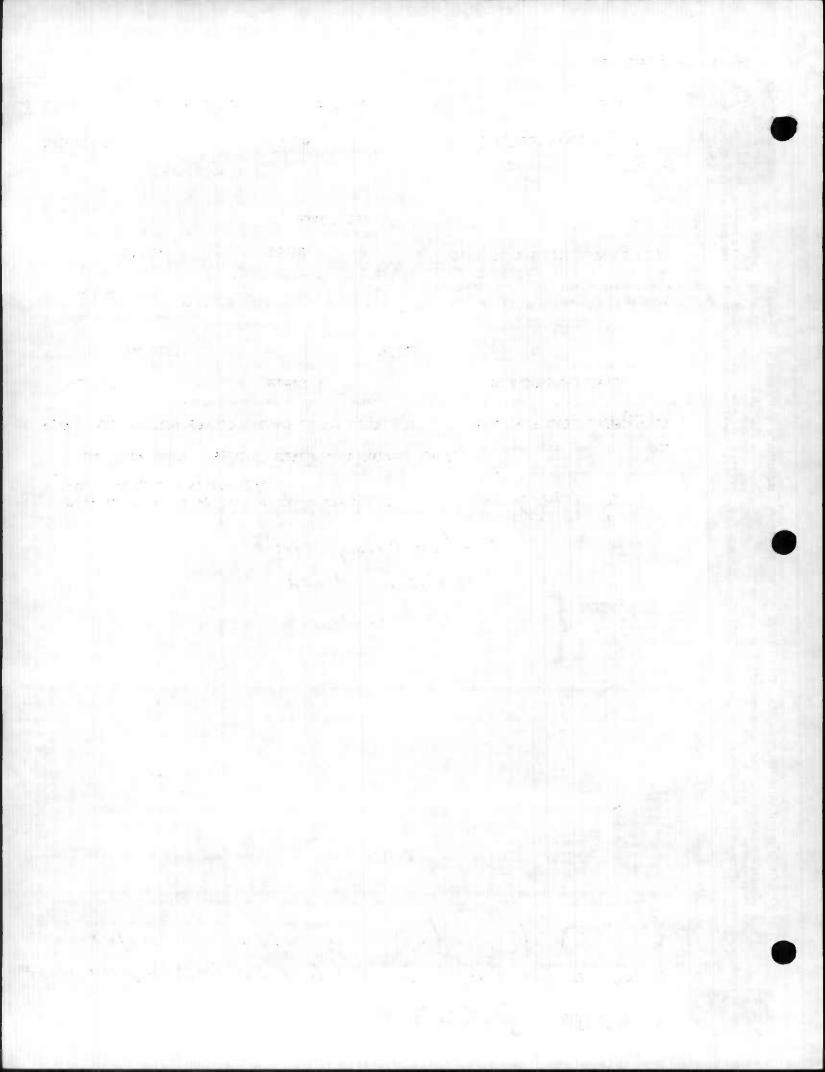
Item 1	a F	er FH Film				Cer	tificate of	Death	2. Dete of Dee	Reg. No.	3	3. Time of Deeth
Physic		E					GORDO	N	JUNE	1, Day		10:05 PI
/Medi Exami		4a Facility Name (/	not institution, giv	ve street and numbe	r)			4b. City, Town, o	or Location of Death			
1		JEWIS	H CONVA	LESCENT	HOM	3		BALTIM	ORE		BA	LTIMORE
Funeral Director		5. Sociel Security N 220–46–]	.123	Sex 7. A 1 □ M 2 💢 F	Age (In yrs. 90	lest birthday) Yrs.	If Under 1 Yea Months Deys			, Year) , 1907	9. Birthp Coul	olece (Stete or Foreign htty) MD
and and		Usuet Residence of 10e. Stete	10b. County		10c. Ci	ty, Town or Loc	eation				1	0d. Inside City Limits
h the Marylan r 28a-f show	tor	MD	N/	'A			BALTIN	ORE				1√ Yes 2□No
th the	Director	10e. Street and Nur					10f. Zip Code			10g. Citizen of V	Whet Cou	ntry?
eath with		6711 PA	RK HEIGH	TS AVE. #	419			21215		U.S		
ter d	by Funeral	11. Meritel Stetus 1 ☐ Never Merri 3 ※ Widowed	ed 2 Married	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates	s? No		Ves Decedent of Yes, specify Cu ☐ Yes 2X1 No		(Specify Yes or No- erto Rican, etc.)	Specify	ck, White,	can Indien, atc. IITE
72 hours naturel,		/5000	15. Decedent's E	ducation		16e. Deced	ent's Usual Occu	upation e during most of v ed)	vorking	16b. Kind of B	usiness/in	dustry
21215-0020 d within 72 hours at giene. r then "naturel", or	Completed	Elementary/Seco		College (1-4o	r 5+)			ed)	VOIA III	MEDIC		
	ဝိ	17. Fether's Neme	First, Middle, Last)		NURS	5	18. Mother's N	leme (First, Middle,	MEDICA Maiden Sumen	-	
id be ental	o Be		BAAC FINK					SARAH			КС	TZIN
Maryiand d 2 should be file th and Mental Hy 7 is marked oth treumatic event	-	19e. Informant's Na	me/Relationship ((Type, Print)		19b. Meilin	g Address (Stree	et and Number or	Rural Route Number	er, City or Town,	Stete, Zij	Code)
a land		LIONELN	SHAPIRO	(NEPHEW)		915	BURNT CF	REST LAN	E SILVE	R_SPRIM 20c. Location -	G, ME	20903
Saltimore, bernit. Peges 1 an Department of Heal mportant: If item iny injury or other		20e. Method of Disp	position	Removel from Stet	206.		ition (Neme of petory or other pl		Dete	20c. Location -	City or T	own, Stete
Dalfilm permit. Peg Department Important: I any injury o			5 ☐ Other (Special	(y)	(ANS		NAH) AIT2 Neme end Add		6/3/98	BALTIM	DRE,	MD
Physician /Medical Examiner	liner	Immediate Cause (disease or condition resulting in death)	Finel	a.				GIVES			1	Approximete Interval Between Onset and Deeth
68 / 60, ifficete be executed g physician and es the burial-transit	Examiner	Sequentially list co	nditions, mediate	J.	Due to (or es e conseq	1 . 1					
ficete be ex physician sthe burial		Sequentially list confidence in ending to improve the cause. Enter Under Ceuse (Disease or that initiated events	rtyIng Injury	C	7 (a thu						
5 0 0	ledical	resulting in deeth) I				or as a consequence	dry to	4				
	an/N			d	•	34 11) 0	, , ,					
d by the	/ Physician/M	Part II. Other signif	leant conditions	contributing to death	but not res	sulting in the un	derlying cause (given in Part I.		tobacco use co Yss 2/3-No		o the cause of death?
vital necorus, r idean. The law requires that certificate has been signed b irector, page 2 should be deter	Completed by								24e. Wes	en autopsy med?	G,	ere eutopsy findings valleble prior to completion of cause deeth?
The law	Соп								10	res 2 No	1	☐ Yes 2☐ No
ysician: 7 ysician: 7 s certifical director, p	Be	25. Wes case refer exeminer?		Hospital:					Deeth (Check only o	one)		
this ald	1. 70	1 ☐ Yes 2 ☐		28e. Dete of In		ER/Outpetien	3LI DOA		g Home 5 Resident	dence 6 Oth		fy)
Attending I or death. actor: After by the funer	ation	1 Naturel 2 ☐ Accident	5 Pending Investigation	(Month, E	Dey Yeer)	Injury	28c. fnj W M 1[ork? □Yes 2□No	200. 00001001	ion injury occur		
UNISION OF SIDE AND A STATE OF SIDE A STATE OF SIDE A SIDE OF	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Place of I	Injury - At h etc. <i>(Speci</i>	ome, farm, stre fy)	et, fectory, offic	9	28f. Location (S City or Tox		ber or Rui	el Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edicai (29a. Certifier (Check only one)		nysician: To the bes miner: On the basis and manner:	of examine							
To the To the Comp	M	29b. Signeture end		: 14	1	WV		JO 7	79	29d. Date signe		
2		30. Name and eddr	ess of person who	completed cause of	deeth (Ite	m 23a) (Type, I	Print) old	Court .	Rd. Ba	thung,	n	s rirop

State Registrar

JUN 0 3 1998



DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death		Reg. No.		
Physician /Medical	Decedant's Nama (First, Middle Charles	a, Last) E. Graber					3, 1998		3. Tima of Death
Examiner	4a Fecility Nama (If not institution Cherrywood	n, giva street and number Manor Nursi				vn, or Location of Deat cerstown		of Death	re
Funeral Director	5. Sociel Security Number 218–01–0678	6. Sax 1 K M 2□ F	Aga (In yrs. last birtl 82	nday) If Undar 1 Year Months Days	If Under 2 Hours	Min. 8. Data of Bir (Month, De Oct. 1	by, Year) 1915	9. Birthol Count Mary	laca (Stata or Foraign try) "Land
72 hours after death with the Meryland natural; or items 23s or 25s-f show disal Examiner must be excited.	Usual Rasidance of Decedant 10a. Stata 10b. County Md. Balt	imore	10c. City, Town	or Location terstown	er Ay			10	0d. Insida City Limits
3a or 28a-fa the rooffed al Director	10e. Street and Number 402 Hight	meadow Rd.		10f. Zip Coda 2113	6		10g. Citizan of U	S.A.	-
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	20e. Mathod of Disposition 1		20b. Place of	Disposition (Nama of crametory or other platathedral Co	ce)	Data	20c. Location	- City or To	wn, Stata
Department Control Important: If any Injury or DOCS.	21. Signatura of Funaral Sarvice		_	22. Name and Addre	ss of Fecility				21117
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** OLIVIA ELIZABETH GILL May 29,1998 1:40 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cherrywood Manor Nursing Home Reisterstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (fn yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 □ M 200/F Months Deys Hours 94 Yrs. 213-74-2109 Director 1, 1903 Balto. Co. Md. Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or item 23s or 28s-f show eny Injury or other treumetic event, the Medical Examiner must be notified at 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 ☐ Yas 2 ☑ No Reisterstown 10e Street and Number 10f. Zlp Code 10g. Citizen of What Country? 13235 Old Hanover Road 21136 USA Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 XNo Specify: py White 3 → Widowed 4 □ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) Housewife Own Home 7 th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John Kerchner Mary Baublitz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 526 Poole Road Roy E. Gill Jr. (Son) Westminster, Md. 21157 20b. Pleca of Disposition (Name of cametery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete 6/1/98 Grace Cemetery Reisterstown, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licansee 22. Neme and Address of Fecliity 11824 Reisterstown Rd. ELINE FUNERAL HOME Reisterstown, Md. 21136 Line 23a. lert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel pneumonia diseese or condition resulting in deeth) Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Fureral Director: After this certificate has been signed by the ettending physician and complately filled in by the intronatid investigate of the part of the sea the burial-transit complately filled in by the funderal director, page 2 should be deteched for use as the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In deeth) Lest Due to (or es e consequença of): Physician/Medical Due to (or es e consequenca of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No Severe dementia à 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical 28. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Information | 1 | Nursing Home | 5 | Residence | 6 | Other (Specify) 1 Yes 2 100 Certification: To 27. Menner of Deeth 1 Neturel 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end piace, and due to the cause(s) end menner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 028304 mn

State Registrar

31. Dete filed (Month, Day, Year)

50

30. Name end address of person who completed cause of deeth (item 23a) (Type, Print)

mai

Reisters town Mn + 32. Registrar's Signature whice Davidson

DHMH 16 Ray 6/95

altimore, Maryland 21215-0020

P.O. Box 68760.

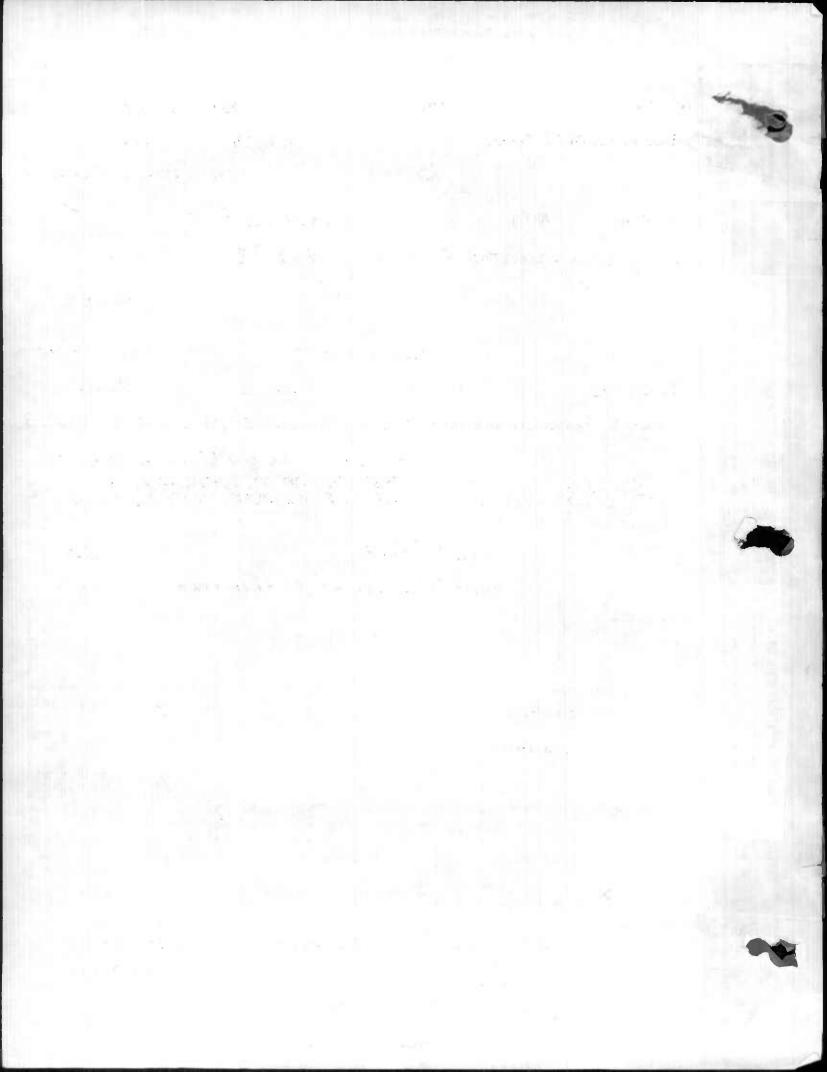
Division of Vital Records,

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Funeral	5. Sociel Security Number	6. Sex 1 M 2 □ F	7. Age (In yrs. lest I	- Months De	eer If Under 24 Hrs			Birthpleca (Stete or Foreign Country)
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or 28a-1 or Director	10e. Street end Number	1-011		10f. Zip Coo			g. Citizen of V	Vhet Country?
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r items 23s sirer must. Funeral	11. Meritai Status		edent Ever in U.S.	13. Was Decedent	of Hispenic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-		e - American Indian, k, White, etc.
or the			2 No	1 ☐ Yes 2 ☑	/	to riloan, otc.)	Specify	
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Hygiene.	17. Father's Name (First, M	Aiddle, Last)	11	1ACHINI		me (First, Middle, M		
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and Mis mar	19e, informent's Name/Rei	lationship (Type, Print)		9b. Malting Address (St			City or Town,	
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of Heaith	20e. Method of Disposition		20b. Place	of Disposition (Neme of	of	Date 2	Oc. Location -	City or Town, State
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State Registrar 31. Date filed (Month, Day, Year) JUN 0 3 1998

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98-3016-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland	Department of Hea	Ith and Mental Hygiene
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NATHANIEL
HICKS

Physic · /Med

Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or frems 23s or 28a-f show eny injury or other traumatic event, the Modical Examinar must be notified at once.

Baltimore, Maryland 21215-0020

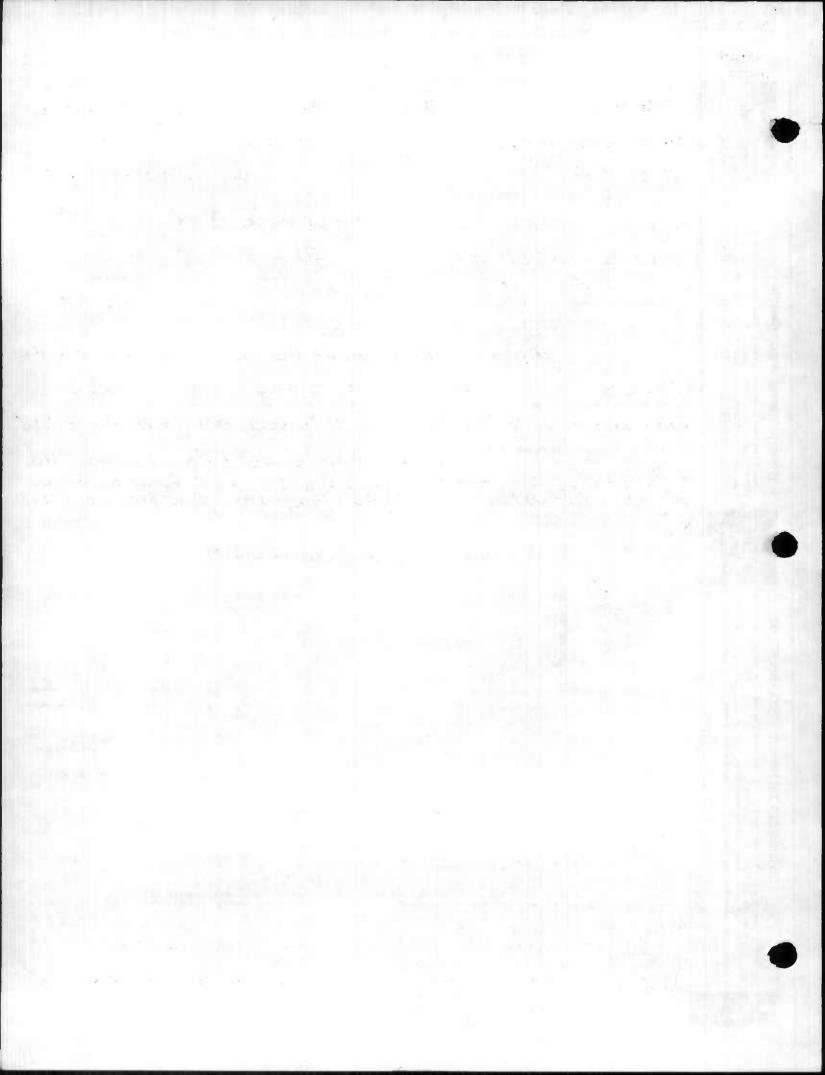
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State of	Maryland / Departm	ent of Health and cate of Death	Mental Hygie		17202
Decedent's Nama (First, Middle, Last) NATHANIEL	HICKS	SR.	2. Data of Deeth Month	Day Year	
4a Facility Name (If not institution, give street end number			MAY or Location of Deeth	27, 1998 4c. County of De	4:36P.M.
UNION MEMORIAL HOSPITAL	557				
	. Age (In yrs. last birthday) If U	BALTIN nder 1 Year if Undar 24 H	lrs. 8. Data of Birth		/A inthplece (State or Foreign Country)
212-65-9846 1 12M 2□ F	45 Yrs. Mon	ths Days Hours M	JAN 16,1	953 NE	EW YORK
10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
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15. Decedent's Education	16a Decedent's	Usual Occupation	166	. Kind of Busines	
(Specify only highest grade completed)	(Give kind o	f work done during most of v T use retired)	vorking	. Tuild of Dusilios	unidadity
Elementary/Secondary (0-12) College (1-4	DISTRIB	1 0		S PAST	AL SERVICE
17. Fether's Name (First, Middla, Last)	DISIRIO		lame (First, Middle, Maid		TE CERVICE
JAMES	HICKS S	70 1			REEN
19e. Informant's Name/Relationship (Type, Print)		Iress (Street end Number on	1		
NATHANIEL HICKS JR. (20a. Method of Disposition	SON) 1517 B	(Neme of	ET, YORLI	HORE I	40.21218 or Town, State
1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from St	cemetery, cremetory	or other pieca)			
4 Donation 5 Other (Specify)	GARRISON	FOREST CEME	6-2-1800	WINGS	MILLS, MD.
21. Signature of Funeral Service Licensea	22. Nam	EPH H. BA	POUN JR.	FUNERA	+L Home
- Wown w	214	ON FULTOR	DAVE. BA	LTIHORE	MD. 21217
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Pert II. Other significant conditions contributing to dea	tn but not resulting in the underly	ing cause given in Pert I.			te to the cause of death'
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			24a. Was an a performed		Were autopsy findings avelleble prior to completion of cause
					of deeth?
			1 Yes	2□No	18 Yes 2□ No
25. Was case referred to medical examinar?			Death (Check only one)		
1 Yes 2 No Hospital: 1 □ Inj	- AA		g Home 5 Residence		pecify)
27. Manner of Death 1 Natural 5 Pending 28a. Dete of (Month)	Dey Year) Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	
2 Accident Investigation	М	1 ☐ Yes 2 ☐ No			
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place o building	f Injury - At home, farm, street, fa g, etc. (Specify)	ctory, office	28f. Location (Stree City or Town, S		Rural Route Number,
29a. Certifier (Check only one) 1☐ Certifying Physician: To the besent and manner.	is of examinetion and/or investige	rred et the time, dete end ple etion, in my opinion, deeth o	ece, end due to the ceus ccurred et the time, date	e(s) and manner end placa, and d	as steted. ue to the cause(s)
29b. Signature and title of certifier		29c. Licanse number	29d.	Date signed (Mo	nth, Day, Year)
May de la Maria	ile	O.C.M.E.	N/	AY 28,19	198
30 Name and address of account of the	of death (item 00s) (** 0 '-*)	O.C.PI.E.	Į IV.	MI 20, 19	790
30. Name and address of person who completed cause MAYMANTA A. KORF		11 Penn Stree	t. Baltimor	e. Marvil	and 21201
			C) DOLUMNI	C, Fidi.y.	CIRC 21201
JUN 0 3 1998 L	gistrar signetus Juna Davidson-R	indell			
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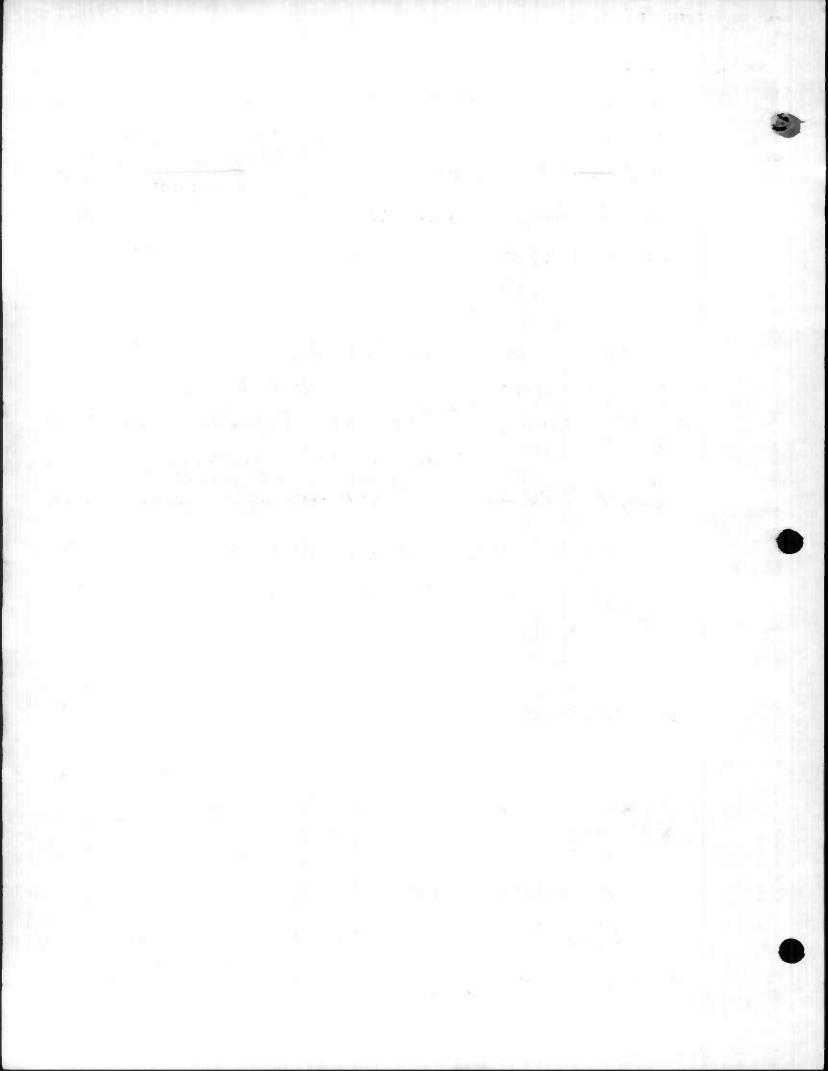
State Registrar



	ī+	em#	5 per FH G760 6/3/98 EW	State of Maryland		ent of Health		/giene	98	17203
			1. Decedent's Name (First, Middle, Last)	11001	20000		2. Date of D Month		Year	3. Time of Death
	Physic /Medi		EUGENE	11510	DERSON		MAY	31 1	998	04:00 AT
9	Exami	ner	4e. Facility Name (If not institution, give s NORTH WEST		ENTER		own, or Location of Dea			
-	Funeral		5. Sociel Security Number 309 6. Sex			nder 1 Yeer If Under	24 Hrs. 8. Date of B	rth		Nore
-	Funeral Director		264-16-4909	M 20 F 81	Yrs. Mon	ths Days Hours	Min. Month, D	ay, Yeer)	Ge	lace (State or Foreign try)
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c City	. Town or Location		JANUARY	16,1917		0d. Inside City Limits
	Manylan f show	٥	Ma 77 11	iore Re	ende 1/c7	-				1 Yes 2 No
	72 hours efter deeth with the Maryland natural; or items 23a or 28a-f show dicel Examinal must be notified at	Director	10e. Street and Number	7(0	101	. Zip Code		10g. Citizen of	What Coun	itry?
	23a o		9420 Allerswoo	d Rd	d	21/33		6	151	4
	items items	Funerai	11. Marital Status	Was Decedent Ever in U,S Armed Forces?	S. 13. Was D If Yes,	ecedent of Hispanic Or specify Cuben, Mexica	rigin? (Specify Yes or N n, Puerto Rican, etc.)	o- 14. Rad Blad	e - Americ ck, White,	
020	the sn	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 PYes 2 No If Yes, Give Year or Dates: WW I	T □ Ye	es 2 No Specify	:	Specify	10/0	a L
2-0	72 hours	ted	15. Decedent's Educ	etion	16a. Decedent's	Usual Occupation	at of working	16b. Kind of B	usiness/Inc	dustry
21215-0020	within Jens.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	T +	f work done during mos T use retired)	st or working	4,	1	
	000		17. Father's Name (First, Middle, Last)	0	DIFECTO	r Of Hous	ING ar's Name (First, Middl	Maiden Suman	nel D	
Maryland	of it o	To Be		terson		HO	Arietta (Samble		
ary	d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (Type		19b. Mailing Add	Iress (Street and Numb	er or Rural Route Num			Code)
	C TO N E		Mrs Demaris Her	oderson	9420H	llenswood	Rd. Kano		n, Md	21/33
Jore	of to		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	ace of Disposition emetery, crematory	or other place)	Date	20c. Location		
Baltimore,	permit. Pag Department Important: I eny Injury o		4 □ Donation 5 □ Other (Specify)	60	LITISON	torest	0/8/98	UWINGS	MI	115 Md.
Ba	permit. P Departme Importan eny Injur		D. L. L. L. L. S	Reald	Jose	Ph L. KU	ss tunera	Trome	und	4 . 4 . 1
	-		234 Part Enter the disease, or complication, or heart failure. List only on	cations that ceused the death	. Do not enter the	mode of dying, such es	s cerdlec or respiretory	errest,	110.	2/2/6 Approximate
	Physician		e smooth, or near failure. List only on	e cause on each line.					Ī	Intarval Between Onset end Death
4	/Medical Examiner		Immediate Causa (Final disease or condition resulting in death)	ACUTE	REN	AL FA	ILURE	-		3 dayn.
		-e	Tooland III down,		as a consequence					nknown.
	be executed sician end burial-transit	Examiner	Sequentially list conditions	DIABET &	as a consequence	MELLIT	0.5			
30,	be executed ician end burial-transi	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
8760	physic s the b	dica	that Initiated events resulting in death) Last	Due to (or	as a consequence	of):				
Box 6	death certificate attending phy defor usa es t	∿/Me	d						i	
	The law requires that the death certificate at has been signed by the attending physipage 2 should be datached for use es the	Physician/Medical	Part II. Other eignificant conditions conf	tributing to deeth but not resu	iting in the underlyi	ng cause given in Pert	i 23b Die	I tobacco uea co	ntribute to	the cause of death?
P.0	that the deed by the datached	Phys	HYPERTENSIO							bably Wunknown
	w requires that sbeen signed to should be date	by	HALSKISION						T 045 141	
Sor	been should	Completed						s an autopsy formed?	evi	ere autopsy findings ailable prior to mpletion of cause
Rec	The law ate has page 2	дшо					10	Yes 2 No		death? ∃Yes 2.5€No
ital		BeC	25. Was case referred to medicel			26. Plac	e of Death (Check only			2 165 AM
Division of Vital Records,	5 00	To	TET ES ZELINO		ER/Outpatient 3		ursing Home 5 Res	sidence 6 Oth	er (Specif	y)
on o	tending Ph leath. tor: After th the funeral	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?		how injury occur	red	
isio	or Attending after death. Director: After din by the fune	fleat	2 Accident Investigation 3 Sulcide 6 Could not be determined	28e. Place of Injury - At ho		1 Yes 2 Ctory, office		(Street and Numi	ber or Rura	al Route Number.
Ö	る名が正	Certification:	4 Homicide	building, etc. (Specify)	,,	City or To	own, State)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completaly filled in by	edical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	Iclan: To the best of my know er: On the basis of examinati	rledge, death occur	rred at the time, date an	nd place, and due to the	cause(s) and made	anner as si	tated.
	the H thin 24 the F mplets	Medi	29b. Signature and tiple of tertifier	and manner stated.	and or invodige	29c. License number	a Joodings at the time	29d. Date signe		
	S T N		Happ	4		D 4272	3 .		3 1	1998
			30. Name and address of person who cor	npleted cause of death (item	23a) (Type, Print)	3745	FOXFORD			RD
			AUNERAHALIT	LIAGICIA	-	RAITIM	200	mp	010	

State Registrar

31. Date filed (Month, Day, Year)
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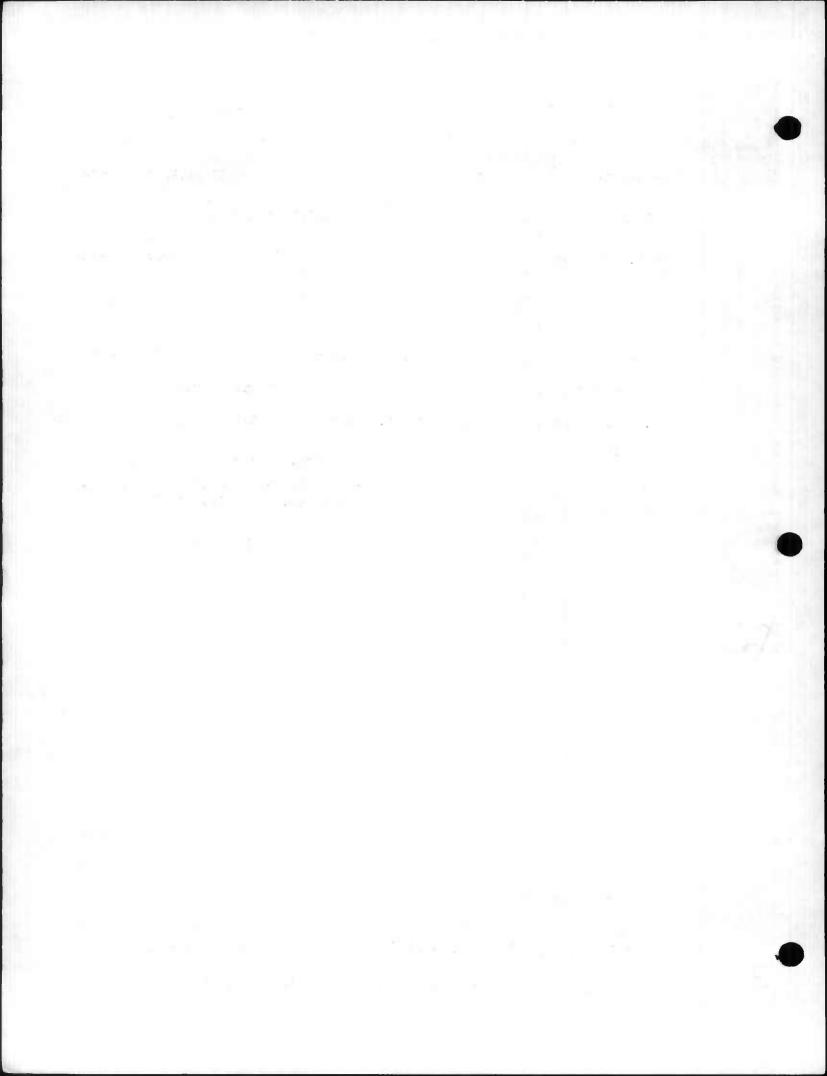


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month EDWARD HARE 16:40 1998 MAY 31 /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Data of Birth (Month, Day, Year) April 29,1944 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days XOM 20F Yrs Director 212-42-7999 54 Maryland Usual Rasidance of Dacadant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits show r 28a-f show Baltimore City Yas 2 No N/A Director Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7 is merked other than "natural", or items 23a or traumatic svent, the Medical Examiner, inval be a 21224 United States 400 S. Eaton Street death Funerai 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 72 hours after 1 √Yas 2 No If Yes, Giva Yaar or Datas: 1 Navar Marriad 200 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: þ 3 ☐ Widowad 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry al Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 Years Truck Driver Moving Company 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnema) 2 should be fill end Mental H permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked oil any injury or other traumatic ever Be Louisa Bartels James Oliver Hare 2 19a. Informent's Neme/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 21224 Wife 400 S. Eaton Street Baltimore, Maryland Mrs. Marie Hare 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Bunal 2 Cramation 3 Ramoval from Stata Hilltop Service Corp. 6/3/98 4 ☐ Donation 5 ☐ Other (Spacify) Towson, Maryland 21. Signatura of Funaral Sarvice Licensaa 22 Nama and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 4 lestos Dundalk, Maryland 7922 Wise Ave. 23a. Part Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, show, or heart failure. List only one cause on each line. Approximata Intarvat Between Onsat and Death **Physician** /Medicai Immediata Cause (Final disaasa or condition rasulting in daath) HYPOVOLEMIC SHOCK Examiner Dua to (or es e consequance of): Examine 8 HOURS ACUTE GASTRO INTESTINAL BLEED Sequentielly list conditions, if any, taading to immedieta causa. Entar Undarlying Cause (Diseasa or injury thet initieted avants rasulting in death) Lest and Due to (or as a consequence of) Physician/Medical Due to (or es a consaguance of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown ISCHEMIC CARDIONIOPATHY, CHRONIC OBSTRUCTIVE PULMOUNCY DISENSE Division of Vital Records. þ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy parformed? Completed peen SEVERE PERIPHERAL VASCULAR DISEASE, LUNG CARCINOTIA. DIABETES page 2 hes 1 Yas 2 No 1 Yas 2 No certificate To the Hospital or Attending Physician: within 24 hours effer death.

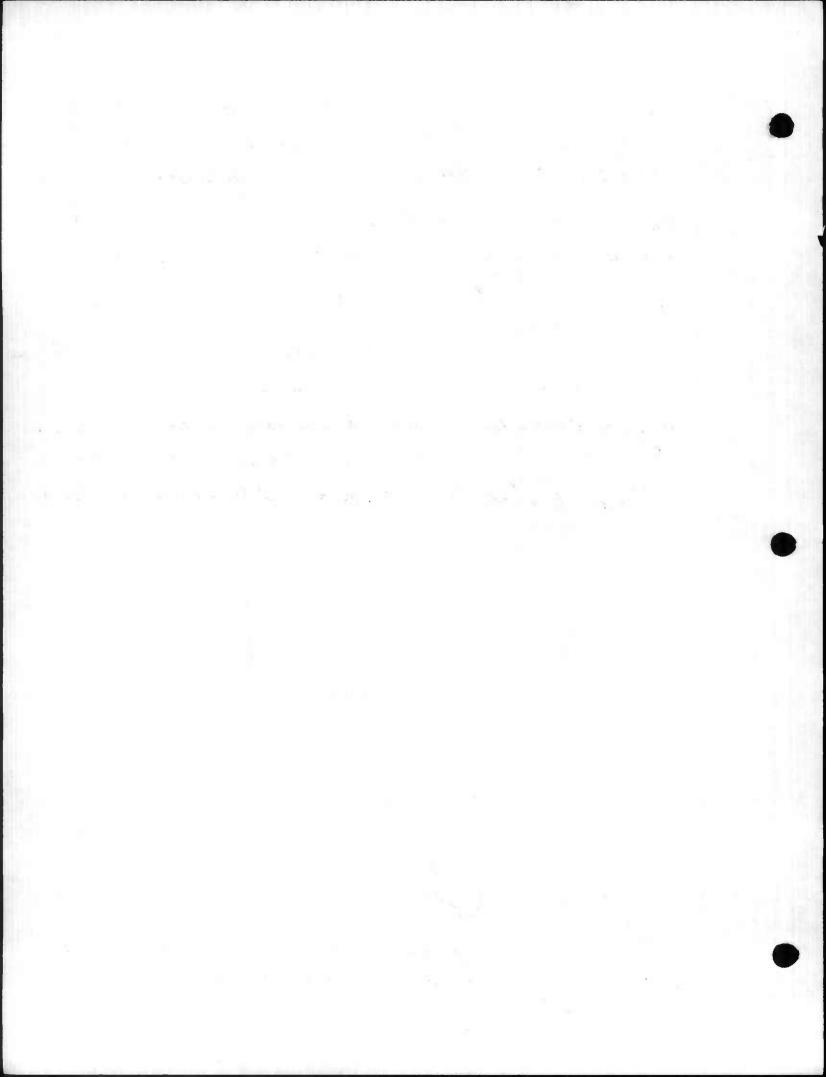
To the Funeral Director: After this certific 25. Was casa rafarred to medicei examinar? Be 26. Pleca of Daath (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 28a. Dete of Injury (Month, Dey Year) 27. Mannar of Daeth 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accident 3 Sulcida 6 Could not ba 28a. Place of tnjury - At home, farm, straat, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 2 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et tha tima, deta and place, and dua to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to the ceuse(s) and manner stated. 29a. Certifian Medicai pletely 29b. Signatura and titla of certifian 29c. Licansa number 29d_Date signed (Month, Day, Yaar) 30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print) Eastern Are Bult. JHBMC aregar 31. Data filed (Morker, Dey, 32. Ragistrer's Signature State rela Davidson Registrar JUN 0 3 1998



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				State of Marylan	•	cate of D			giene Reg. No.	8 1.	7205
	Physic		1. Decedant's Nama (First, Middla, La Herman	st)	H	ollis		2. Data of De Month	Day	998 3	3. Tima of Death AM
	/Medi Examii		4a. Facility Name (If not institution, giv	1. Center	last birthday)		City, Town, or Lo Ballo if Under 24 Hrs.	cation di Deet	4c. County	of Death	
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	lanyand show ed.el	2	10a. Stata 10b. County		y, Town or Location						Inside City Limits
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and 21	be filed will stall Hygiens of other that event, that	Be Completed	17. Fathar's Nama (First, Middla, Last)		MAIL		8. Mother's Name SARA	1	Maidan Sumam	ne)	Service
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Baltimore, M	Pages 1 and 3 nent of Health net; If Been 27 I any or other tr		MARIAM Cro 20a. Method of Disposition 16 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Othar (Specify	Inamoval Itom Stata	Pleca of Disposition rematary, cramator	(Name of v or other place)	Cen 6	Data	BALTA 20c. Location - BULT	City or Town,	Stata
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ecords	iaw requires that ias been signed t a 2 should be det							24a. Was perfo	an autopsy med?	svallat	autopsy findings bia prior to etion of cause th?
ital F	sicien: The law certificate has b sirector, page 2 s	Be Cor	25. Wes casa rafarred to medical				26. Placa of Death		ras 20(No	1 □ Yε	as 25 No
> t <	Physician: this certific rai director,	ToB	exeminer? 1 ☐ Yas 2 Ø No	Hospital: 1 ☐ Inpatient 2月	ER/Outpatient 3	DOA Other:				er (Specify)	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Mannar of Death 1 Natural 2 Accident invastigation 3 Suicida Could not be datermined		28b. Tima of Injury Nome, ferm, street, f		is 2 □ No		now injury occur Street and Num b vn, Stete)		outa Number,
	To the Hospital of Within 24 hours at To the Funeral D completely filled it	edical Ce	29a. Certifier (Check only one) Certifying Ph Certifying Ph Certifying Ph	ysician: To the best of my knowniner: On the basis of examinet	wladge, deeth occi	urred at the tima, jetion, in my opin	, data and placa, a lion, death occurre	and dua to tha ed at tha tima,	cause(s) and ma data and place,	nner as stated	d. e cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of cartifiar	and mannar stated.		29c. Licansa r	numbar		29d. Date signa	d (Month, Day	r, Year)
			30. game, and address of person who arrives change	completed causa of daath (Itam, MD. Johns I	123a) (Type, Print) Hoplans	Hospita	O Baltin	nore m	10 212	05	
P	Sta	ite	31. Dete filed (Month, Pay, Year)	32. Registrara Signa	D. 50.	1.00					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** HATTIE ITENDER SON 12:50 AM MAY 1998 /Medicai 4b. City, Town, or Location of Dear 4a. Facility Neme (If not Institution, give street and number, 4c. County of Death **Examiner** COLUMBIA, HOWARD CO. HOWARD COUNTY HOSPITAL MD If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Date of Birth (Month, Day, Year)
JUNE 28,1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funerai** 1□M 2¶0F Months VIRGINIA Yrs. 81 Director 217-07-3246 Usual Residence of Decedant the Maryland 10a. State 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28a-f show treumstic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Yes 2□No Director MARYLAND HOWARD CO. **JESSUP** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8759 MISSION ROAD. 20794 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other treumatic event, the Medical Exercises. 1 Yes 2 YNo If Yes, Give X Yaar or Dates: 1 Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: py 3 X Widowed 4 ☐ Divorced Specify: AFRO. AMERICAN 18a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be ROBERT SMITH 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1715 N. PULASKI STREET, BALTIMORE, MARYLAND 21216 SUSIE B. EADES DAUGTHER 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL PARK 5/30/98 LAUREL, MARYLAND 21. Signature of Funeral Service Licenses ESTEP BROTHERS FUNERAL HOME, P.A. ESTEP BROTHERS FUNERAL HUME, 1300 EUTAW PLACE, BALTIMORE, shock, or heart failure. List only one cause on each line. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Cause (Final CONGESTIVE HEART PAIWRE diseese or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner PAILURE RENAL 3MO buriel-transit Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last and Due to (or as a consequence ot): Box 68760. physician s the buriel CARDIOMYOTATH Physiclan/Medical 1 EF Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? Division of Vital Records, P.O. signed by t CARCINIMA 1 Yes 2 No 3 Probably 4 Unknown 072 ģ 24b. Were autopsy findings available prior to complation of ceuse of daath? Completed 24a. Was an autopsy performed? hes 2 ANO certificate 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours efter deeth.
 Funeral Director: After this certifica Be 25. Was cese rafarred to medical examinar? 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No 2 Accidant investigation 6 Could not be datamined 3 Suicida 28e. Place of Injury - At home, tarm, streat, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as atlated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. Medical 29a. Certifian (Check only one) To the To the To the I 29b. Signeture end title of certifier 29d. Date algned (Month, Day, Year) 29c. Licanse number MAY 26th 1998 HICKORY RIPGE RUND LOUMBIA MPZIOLY 30. Name and address of parson who complated card a of death (item 23a) (Type, Print) InTIAZH, CHOWN HRY 101

32. Registrar Signature

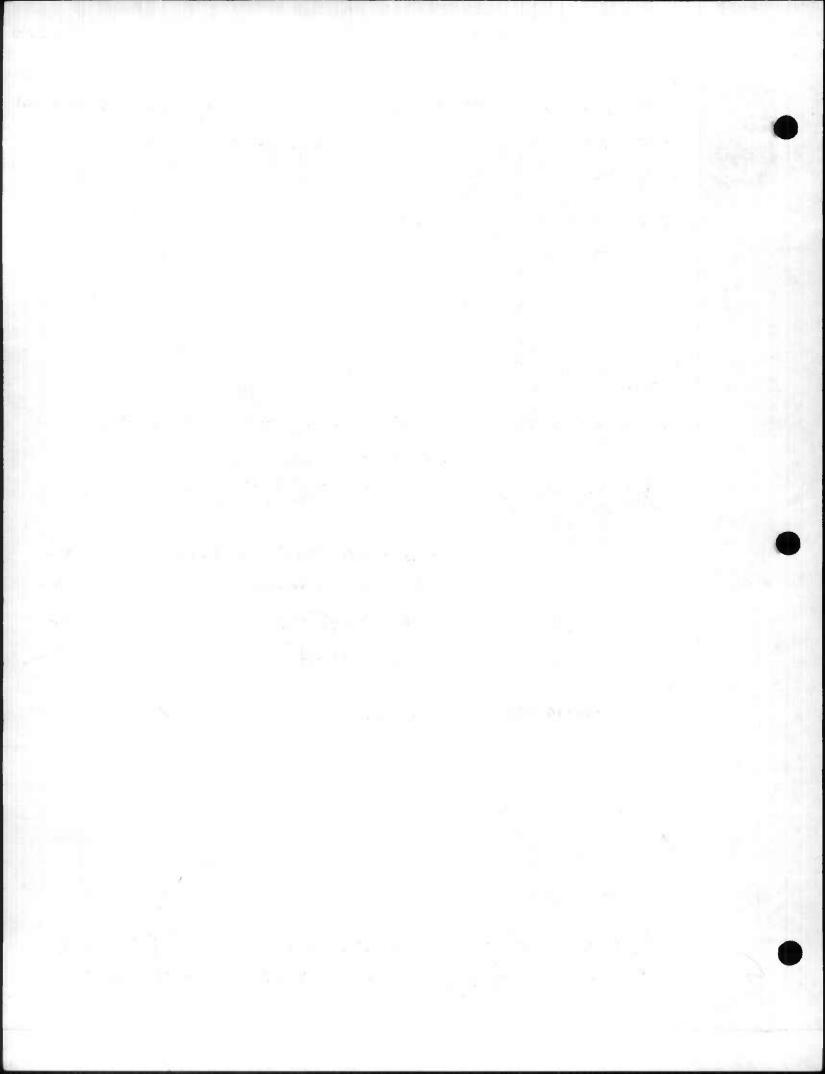
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Registrar

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

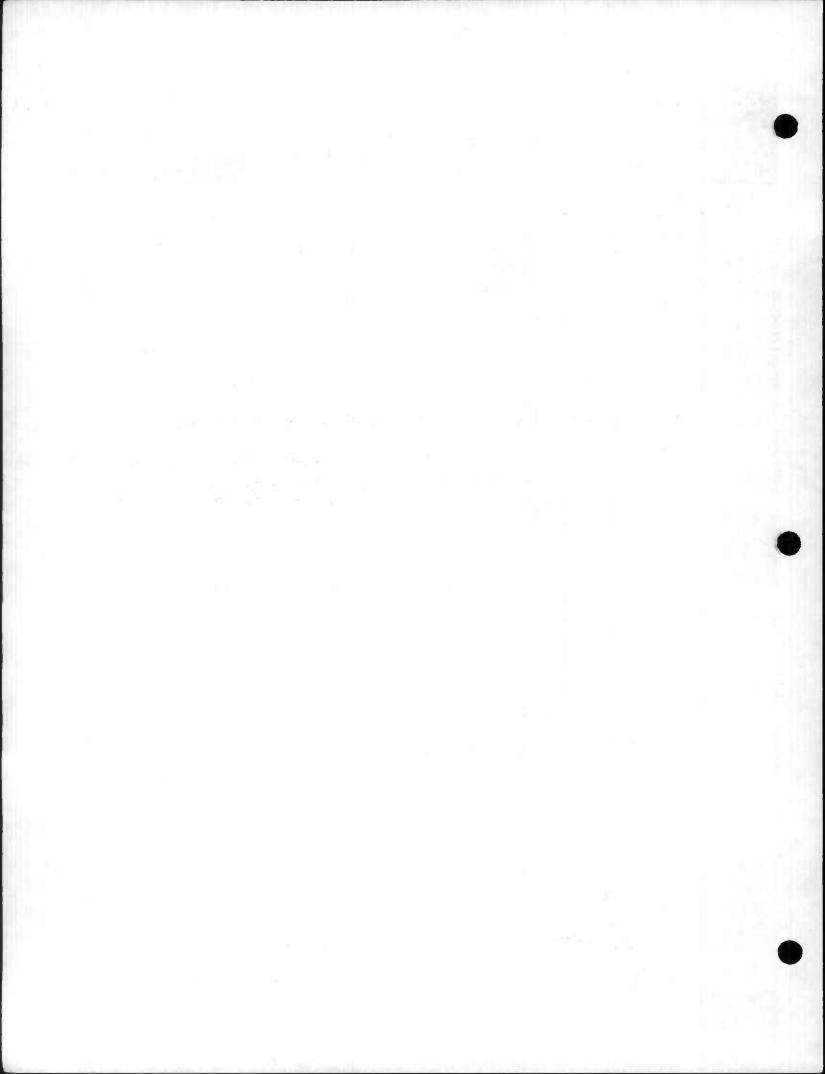
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Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Death **Physician** Month NAOMI HARTMAN :22 1998 NN 01 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE HORMINI BAYVIEW MEDICAR MARYUMD JOHNI If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, **Funeral** 1 □ M 2√2 F Days 218-22-3437 93 Director 1905 Maryland Usuel Rasidance of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Md. n/a Director Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? ö 1435 S. Charles Street 21230 USA Items 23a Funeral 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Depertment of Heelth and Mantel Hygiene. Important: If them 27 is marked other than "natural", or her any injury or other traumats. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home Owner 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Sudbrook Rose Ella Adams 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Morawski Neice 1435 S. Charles Street Baltimore, Md. 21230 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cramatory or other place) Data 20c. Location - City or Town, Steta June 4 1 X Burlel 2 ☐ Cremetion 3 ☐ Removel from State Cedar Hill Cemetery 4 Donetion 5 Other (Specify) 1998 Brooklyn Park, Md. 21. Signeture of Funerel Service Licensee Kevin Ecker 22. Name end Addrass of Fequity
McCully-Polyniak Funeral Home
130 E. Fort Ave. Baltimore, Md. 21230 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Physician/Medical Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceusa (Diseese or Injury that initiated events resulting in deeth) Lest pue physician east the bunial-t P.O. Box 68760, Due to (or as a consequence of) Pert II. Other significant, conditions contributing to death but not resulting in the underlying causa givan in Pert I. 23b. Did tobacco uea contribute to the cause of death? 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings evaileble prior to completion of cause of daath? Completed 24e. Wes en eutopsy performed? page 2 20 No Hospital or Attending Physician: 25. Wes case raferred to medical exeminer? Be 26. Piece of Daath (Check only one) 1 Yas 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To Othar: 4 Nursing Home 5 Residence 8 Other (Specify) this funerai 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred After 1 Netural 2 Accidant To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 5 Pending Investigation 1 Yas 2 No 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29e. Cartifier (Check only one) to Certifying Physician: To the bast of my knowledge, death occurred et the time, data and plece, end due to the cause(s) and manner as steled.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, data and place, end due to the cause(s) end menner steled. edicai 29b. Signeture and the of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name en eddrass of person who completed cause of daeth (Itam 23a) (Type, Print) HOPKINI BAYVIEW MEDICAL CONTER S. KESWANI JOHNS 31. Dete filed (Month, Day, Year)
JUN 0 3 1998 State Registrar



State of Maryland / Department of Health and Mental Hygiene 98 17208 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 30 Day **Physician** HUNTER DOROTHY 1:30 AM /Medical 4a. Facility Name (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NORTHWEST BALTIMORE HOSPITAL RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey 5. Social Security Number 6 Sex 7. Aga (In yrs. lest birthdey) **Funeral** Birthpiaca (Stete or Foreign Country) Months Days 1 □ M 280 F 245-20-5436 Yrs. 74 Director 23/1924 N. Carolina Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE REISTERSTOWN 28a-f sh notified 1 ☐ Yes 2 No Director 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 200 Highfalcon Road 21136 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Herman Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, White, atc. the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 ò 1 Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education 16a. Decedent's Usual Occupation 16b. KInd of Business/Industry (Give kind of work done d life. DO NOT use retired) (Specify only highast grede completed) during most of working Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) In Home Housewife 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Pages 1 and 2 should be nent of Health and Mental Jessie Fleming Pauline D. Martin 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) nt of Health a till Item 27 is or other tra-200 High Falcon Rd., Reisterstown, MD21136 Rev. Molester Hunter altimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 6/4/98 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from Stete Garrison Forest Vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility
LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 iter the disease, or complications thet camed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart lature. List only one ceuse on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Ceuse (Final ATHEROSCUEROTIL CARDIOVASCULAR disaase or condition resulting in death) Examiner Due to (or as a consequenca of) The law requires that the death certificate be executed the burial-transit pue Sequentielly list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): 50x 68760. Physician/Medical Due to (or as a consequenca of): Se Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? signed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably of Vital Records, by 8 page 2 should 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? has certificate 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminer? 20 Hospital: 1 ☐ Inpatient Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 No 2ĂER/Outpatient 3□ DOA 1 Yes this s after death.

I Director: After this of in by the funaral di 27. Maymer of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Attending Naturai Accidant 5 Pending Investigation 1 Yes 2 No 3 Suicida 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide ŏ 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the To the I and manner steted. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) D43481 MAY 30, 1998

State Registrar

31. Date filed (Month, Dey, Year)
JUN 0 3 1998

MICHAEL

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

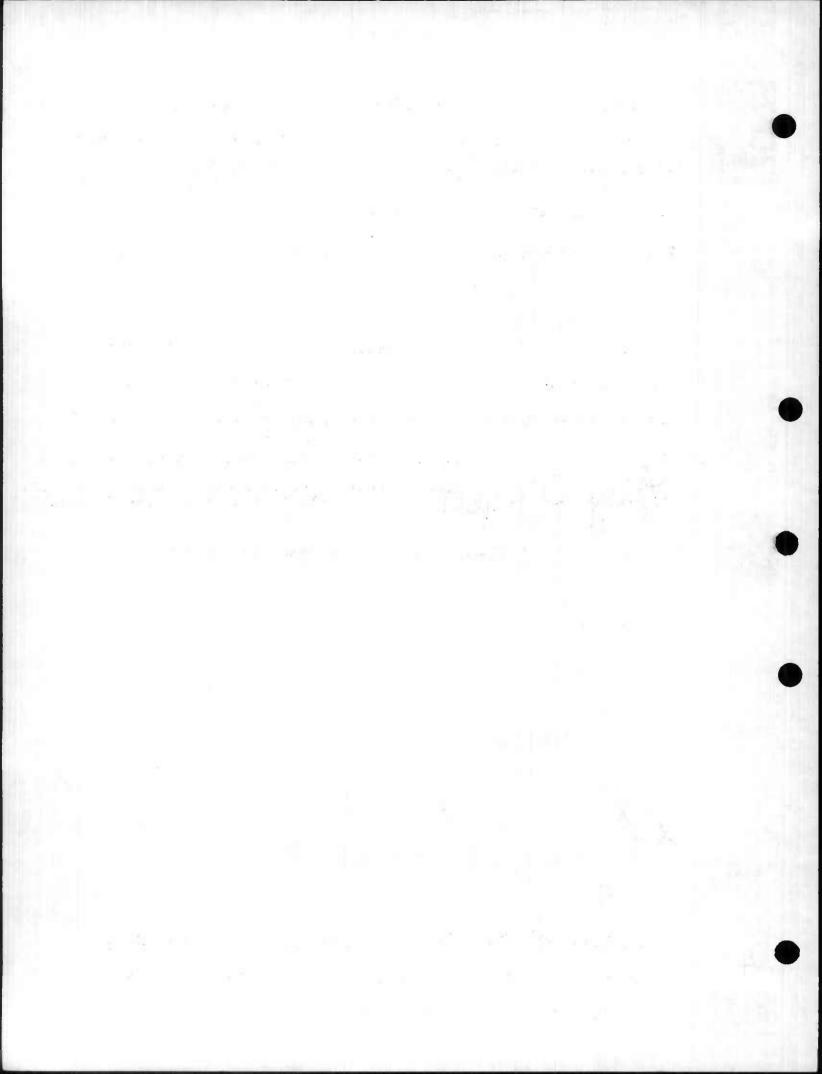
ROTHKIN 5401 OLD COURT

32. Registrar's Signature

Fundam Andrea

ROAD

RANDAUSTONN, MARYLAND 21133



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death Day Yaai MAY 30, 1998 6:27 FM ROSAMOND JEAN HARRIS 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foraign Country) 5. Sociei Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F Months Days Hours Min 219-50-9143 Oct 26, 1906 | Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland N/ABaltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 3 W. Melrose Avenue 21210 13. Wes Decedant of Hispanic Origin? (Specify Yes or NoIf Yas, specify Cuben, Mexicen, Puerto Rican, afc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Datas: 14. Race - American Indian. Black, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com, 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) NAME WITHHELD NAME WITHHELD 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Alan Edgar Harris, Esq. 10109 Century Drive, Ellicott City, MD 210/42 of Disposition (Neme of Town, State 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State Druid Ridge Mausoleum 6/2/98 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ucom 22. Nama and Address of Facility Mitchell-Wiedefeld Home Martin D. Lawson Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervel Between Onsat and Death Immediate Cause (Finel disease or condition resulting in death) RESPIRATORY FAILURE 12 HOURS Due to (or as a consequence of): PNEUMONIA Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lasf Due to (or as a consequence of): Dua to (or as a consaquence of) 23b. Did tobacco use contributa to the causa of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 4 Unknown 1 Yee 2 No 3 Probably 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes an eutopsy performed? 25. Wes cese referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatienf 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of

P.O. Box 68760, the 58 signed t Division of Vital Records, page 2 s funeral After

Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show a notified at

7 is marked other than "naturel", or items 23a or traumstic event, the Medical Examiner must be a

h and Mental h

Department of Health a Important: If Item 27 is any injury or other tran once.

Physician

/Medical

Examiner

Pages 1 and 2 should be

tallio, Kiramand

Directo

Funeral

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Physician/Medical þ Completed Be 10 Certification: or Attending after death. 24 hours a

Medical within 2

27. Manner of Deeth

1 Netural

2 Accident 5 Pending investigation 3 Sulcide

29a. Certifier

(Check only one)

6 Could not be determined 4 ☐ Homicide

28e. Date of Injury (Month, Dey Yeer)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and dua to the cause(s) end menner stated.

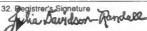
29b. Signeture and title of certifier

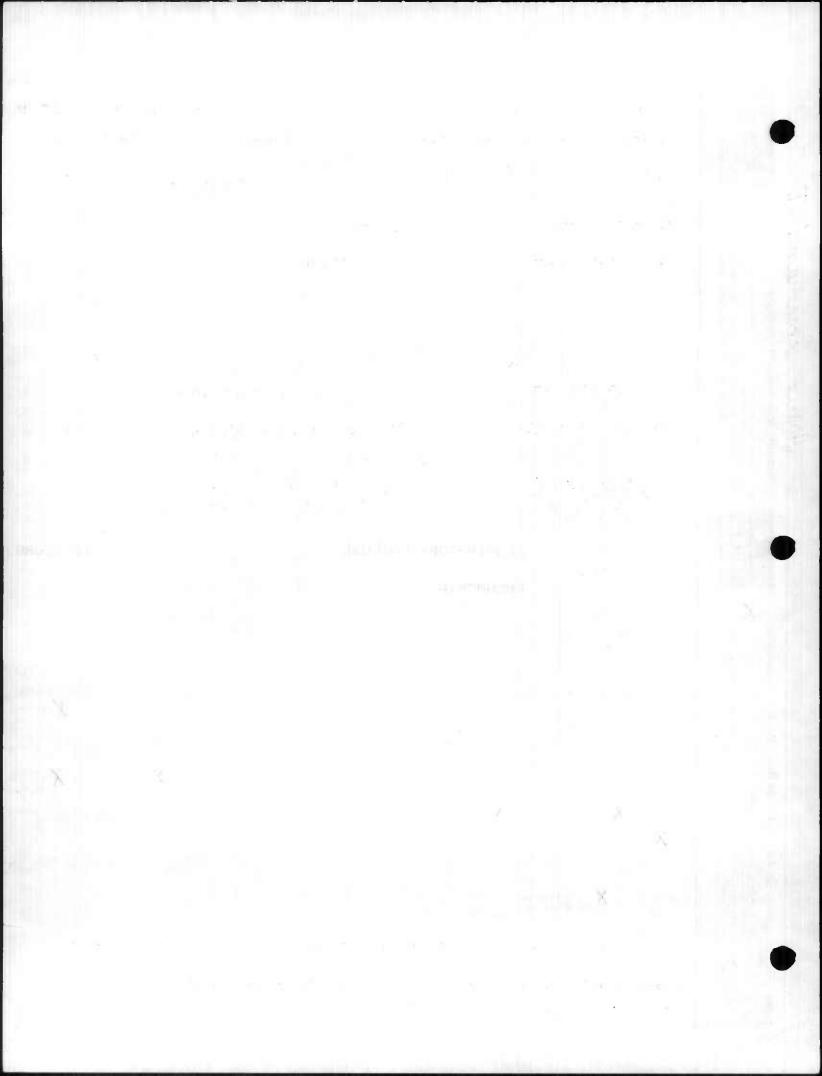
29c. Licansa number D 30263 29d. Date signed (Month, Day, Year) 5-30-98

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

7620 YORK ROAD TOWSON, MARYLAND 21204 FRANCIS KHOO M.D.

State Registrar 31. Dete filed (Month, Dey, Yeer) JUN 0 3 1998





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle 1 ast) 2. Dete of Deeth **Physician** Month 9:24pm Michael A. JOHNSON May 30 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE MERCY MEDICAL CENTER NIA If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year If Under 1 Year 5. Social Security Number 9. Birthplece (State or Foreign Country)
MARYLAND 7. Age (In yrs. lest birthday) **Funeral** Sex 1M 2□F Deys 218-64-0533 40 Yrs. AUG 16, 1957 Director Usuel Residence of Decedent the Marylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 18 Yes 2□ No BALTIHORE CIT Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 709 AGER STREE 21202 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 212 No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MariteL8tetus permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 11 Never Merried 2 ☐ Married 1 ☐ Yes 2 1 No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) CHRISTOPHER PLACE 12++GRADE LYRS 17. Fether's Neme (First, Middle, Last) AVON WILSON 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY BUTLER 3600W. (MOTHER ST., APT. GR, BALTO, HD. 21229 Date 20c. Location - City or Town, State other t Baltimore, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or KING HEMORIAL PARK 6-5-98 WOODLAWN, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

JOSEPH H.

2140 N. FU 21. Signeture of Furnirel Service Licensee 21. Signeture of Fun rel Service Licensee

22. Name and Address of Facility

32. Name and Address of Facilit **Physician** /Medical Immediate Cause (Finel END STAGE ADQUIRED INMUNE DEFICIENCY diseese or condition resulting In deeth) sk years Examiner Due to (or es e consequence of) Examiner Day 1 TOXOPLASMA GONDII physician end the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest PNEUMOCYSTIS =16 Day 1 CARINIT PNEUMONIA Physician/Medicai as 980 signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? should 24a. Wes en eutopsy performed? Completed 1 Yes 2 No funeral director, 25. Wes case referred to medical exsminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation e Hospital or Attendin 124 hours efter deeth. e Funeral Director: Aft NIA 1 ☐ Yes 2 ☐ No NIA NIA 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide NIA TEX Certifying Physicisn: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Msdical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi Medicai (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Yeer) - thysician 30,1998 P09732 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) CUNNINGHAM - MERCY MEDICAL CENTER 301 ST PAUL PLACE, BALTIMORE, MD KOCHELLE 32. Registre Signature
Spilia Davidson-Randall 31. Dete filed (Month, Day, Year) 21202 State

DHMH 16 Rsv 6/95

Registrar

JUN 0 3 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 4 35 AM Month JOHNSON SARAH June 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) of Hospital Baltmore nivers, to Mayland Baltmore MD 9 Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 242-14-718 Months Days 1 M 2 XF Carolina Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 1 XYes 2 □ No timor Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 L 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Baca - American Indian 11. Maritel Stetus Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. De NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) rest 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Relationship (Type, Print) (nephew Mel 1d. 2/2/6 To. 20b. Place of Disposition (Name of certificity of other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 Removel from State sdowne, -10r 4 □ Donation 5 □ Other (Specify) 22. Name and Address of I 21. Signature of Funeral Service/Licensei The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, the failure. List only one cause on each line. Md. 21216 Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) (or as a consequence of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown Chranic Lymphocytic Leukemia 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? Congestive Heart failure, chronic obstructive Phonory disease, Schrophrenia 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 1 Tyes 20 No 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 en Department of Heelt Important: If Item 2: any Injury or other: p0029.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show

Pages 1 and 2 should be filed within 72 hours after deeth nent of Heelth and Mental Hygiene.

In it! If them 27 Is marked other than "natural", or itema 23 my or other traumatic event, it a keolesi Energie in many or other traumatic event, it as keolesi Energie in many or other traumatic event, it as keolesi Energie in many or other traumatic event, it as keolesi Energie in many or other traumatic event, it as keolesi Energie in many or other traumatic event, it as keolesi Energie in many energies.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

the Meryland

Examiner physicien and the buriel-transit Physician/Medical þ Be Completed

Certification: To

Medical

signed t s certificate hes b director, this funeral After ofter deeth Director: /

lew requires that the death certificete be executed

or Attanding Physician;

4

0

Division of Vital Records, P.O. Box 68760

1 ☐ Yes 2 No

27. Menner of Deeth

1 Netural

2 Accident 3 Suicide

4 | Homicide

29a. Certifier

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Dete of Injury (Month, Day Year)

end menner steted.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 Yes 2 🗆 No 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and titlefol certifier am

5 Pending investigation

6 Could not be

INTOOL

29c. License number

29d. Date signed (Month, Day, Year) June

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARQUET GLEUN

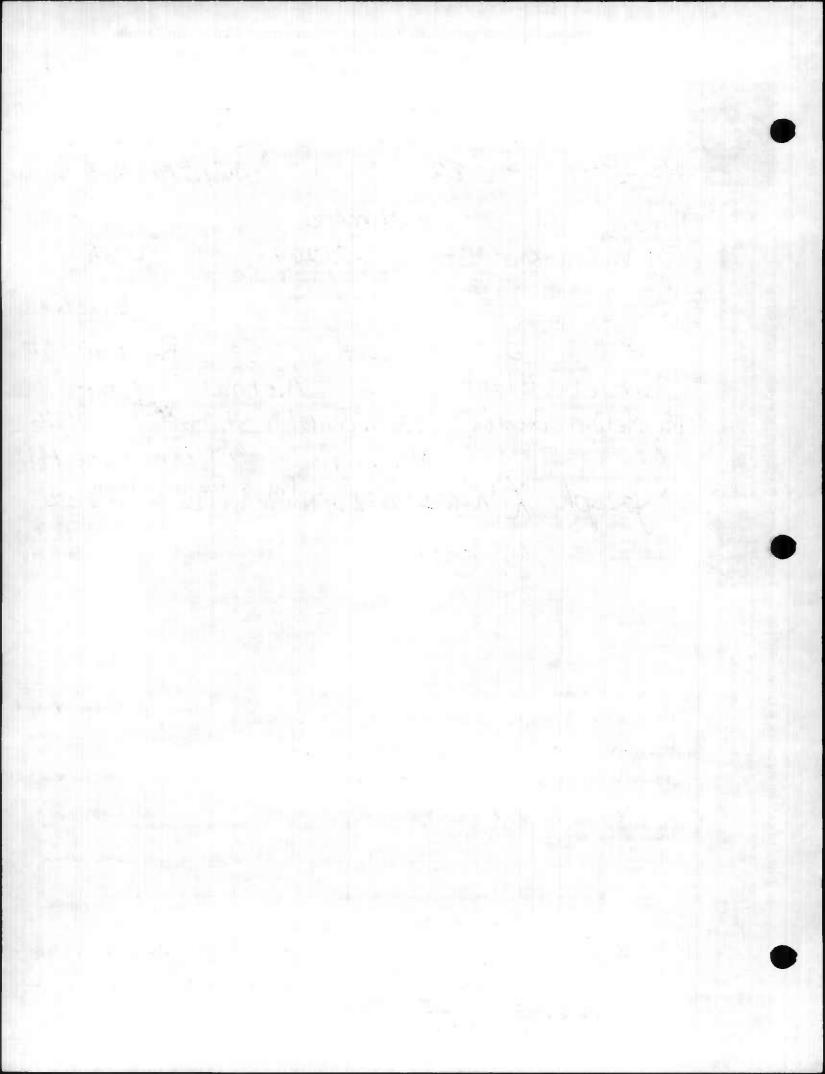
22 South Greene Street Baltimore M.D.

State Registrar 31. Date filed (Month, Dey, Year) JUN 0 3 1998 32. Registrary Signature

Hospital: 1 SInpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of

within 24 hours eft To the Funeral Di completely filled In



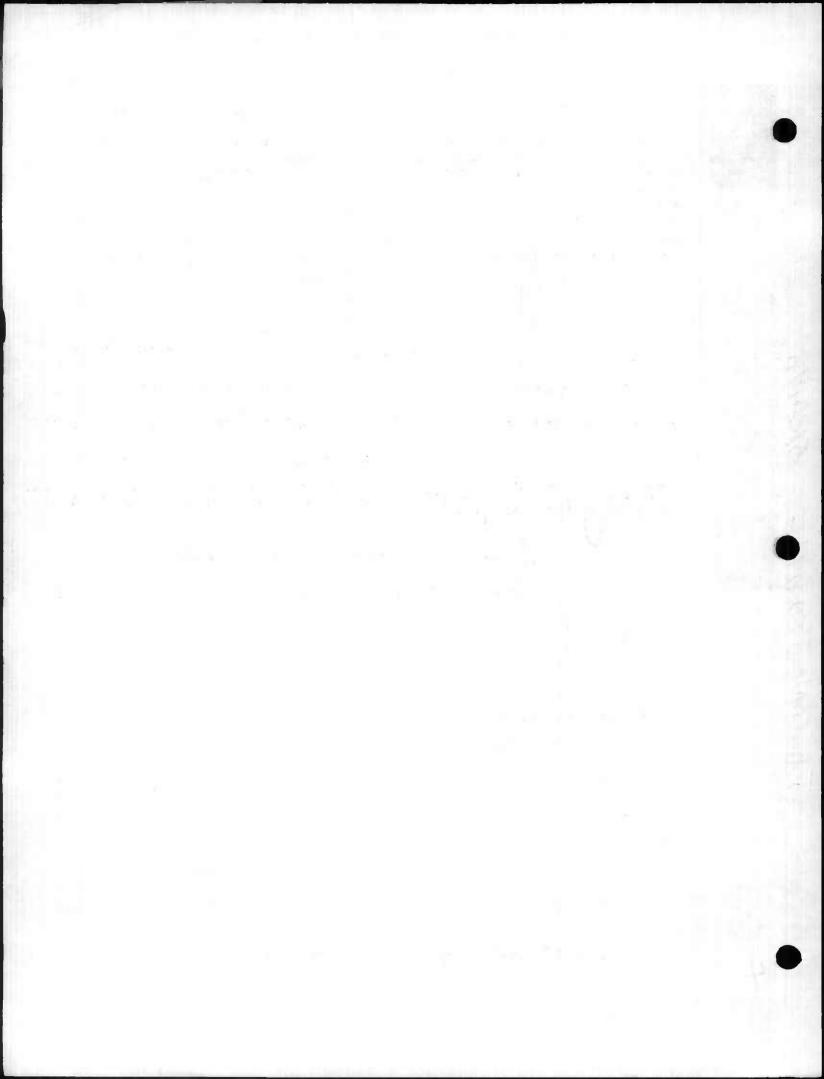
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time I th 30th **Physician** ISABELLE G. JOHNSON MAY 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caton Manor Nursing Home Baltimore Hours Min. 10/12/1903 5. Social Security Number 7. Age (In yrs. last birthday) If Undar 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days 219-10-7799 1 □ M 20 F 94 Maryland Yrs. Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumstic event, the Maxical Examinar must be notified at MD n/a Baltimore Director Was 2□ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1925 Division Street 21217 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? natural, or Items 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian. Black, Whita, etc. 1 Never Marriad 2 Married ☐ Yes 2 X No f Yes, Give **Black** 1 ☐ Yes 2 No Specify: by Specify: 3 2 Widowed 4 □ Divorced Yaar or Dates: Completed permit. Peges 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany or other traumatic event, if Health ADRS. 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domino Sugar 12th Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) William Bailey Annie Laverne Lee 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Isabelle L. Simons 1925 W. Franklin Street, Balto., MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 6/5/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Z Name and Address of Facility & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 Do not enter the moda of dying, such as cerdiac or respiratory arrast, Approximata Intervel Between Onsat and Death **Physician** eart Parlure Immediate Cause (Final disaasa or condition rasulting In death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last the Due to (or as a consequence of): ettending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes director, 25. Was case raterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yes 25 No Certification: To o funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation Division or Attending 1 Natural 2 Accident deeth. 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral Dir completely filled in hours (15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) and manner stated. 29a. Certifier edicai 24 To the To the To the 29b. Signature and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) Attending Social

State Registrar 31. Date filed (Month, Day, Year)

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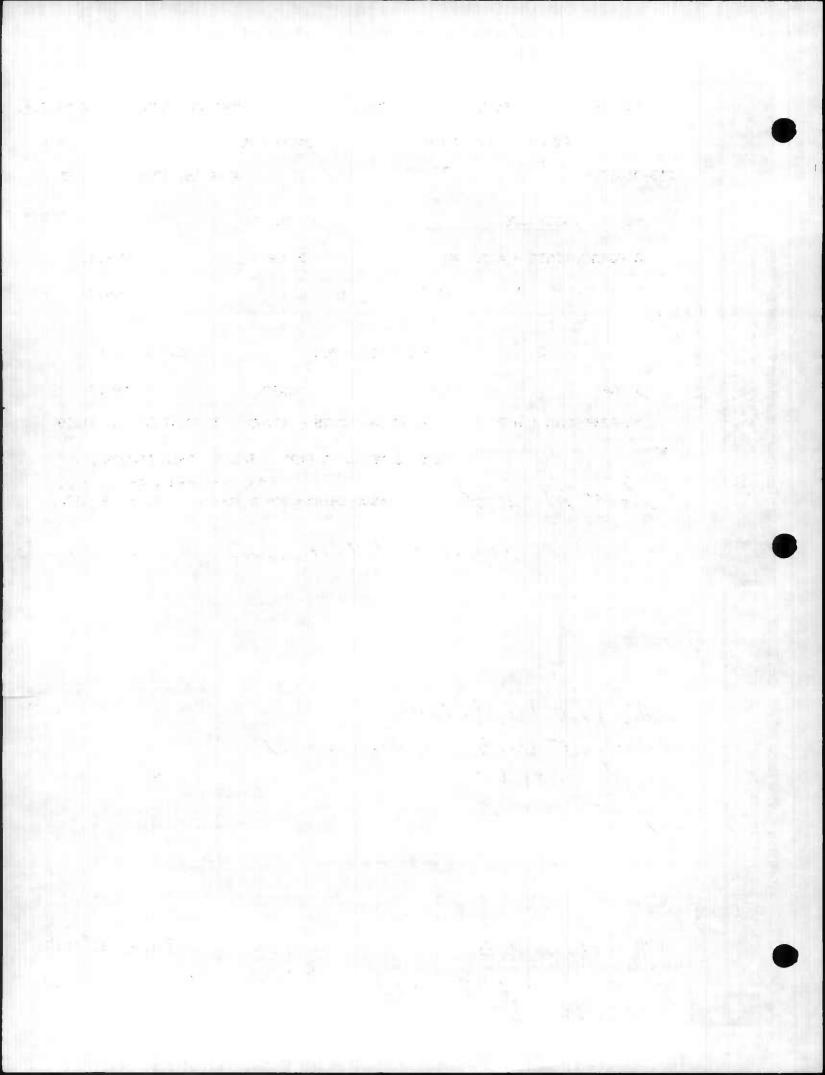
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

CN-CTRIAC-MD \$109 R FCHIR_ Hwy 32. Registrar's Signature relie Tavidson Pandell



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** MAY 30, MORRIS **JACOB** KATZ 1998 4:55 P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) **Examiner** LEVINDALE NURSING HOME BALTIMORE N/A 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Yrs. 79 **Director** 213-01-6328 JUNE 16, 1918 MD Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 25 No ecto MD BALTIMORE PIKESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 늄 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mentel Hyglene. Important: if Item 27 is marked other than "--- ance. In the contract of the traument of the traument." "naturel", or items 23s or addical Examiner must be 8 POMONA NORTH - APT. ONE 21208 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1♥ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married WWII 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER OPERATOR C.P.A. FIRM 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **JACOB** KATZ 2 BESSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) FRANCES KATZ (WIFE) 8 POMONA NORTH - APT ONE PIKESVILLE, MD 21208 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete XBurial 2 Cremation 3 Removal from State 6/2/98 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Baltimore, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Gleanous Cell Capanione Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequenca of) 20 USB to signed by the a d be deteched f Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? bleddes Cancer 1 Yee 2 No 3 Probably 4 Unknown ò 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? erebrevasules accident pure des os de 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: 25. Was da'se referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 PInpatient 2 □ ER/Outpatient 3 □ DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 5 Pending 1 Natural death. 1 Tyes 2 No Investigation 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Director of the Fu 2 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner es stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jane 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2434 & Reluedere aue Baltiroge a 31. Date filed (Month, Day, Year)
JUN 0 3 1998 State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Item 20b,c Per FH Film G760 6-3-98 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year Kornblit May 29, 1998 David 2:43pm4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth 9. Birthplece (State or Foreign Country) Sinai Hospital If Under 1 Yeer 8. Dele of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Months Deys Hours 1₽M 2□ F 89 Yrs 213-32-2226 Jan. 15, 1909 Poland Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 ☐ Yes 2X No Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2708 Summerson Rd. 21209 U.S.A. Raca - American Indien, Bleck, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ②No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-tif Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 Married 1□ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondery (0-12) College (1-4or 5+) 12 Tailor JoS Banks 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) NIA Gershon Kornblit 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 2708 Summerson Rd., Dora Kornblit Wife Baltimore, MD 21209 20b. Plece of Disposition (Name of 20a. Mathod of Disposition 20c. Location - City or Town, Stete Lubawitz Nusah Ari Rosedale 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 06/02/98 Baltimore 4 ☐ Donelion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Fugerel Service License Sol Levinson & Bros., Inc. 8900 Reisterstown Road Baltimore, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiratory errest, shock, or have feiture. List only one cause on each line. Immediate Ceuse (Final disease or condition rasulting in death) 5 xlor Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in daath) Lest Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Abdominal Gortic aneurysm 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings eveilable prior to completion of cause of daath? Parkinson's Ocsease 24e. Was an eutopsy COPD 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case raferred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2DNo 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred

Physician /Medical Examiner

that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or hams 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

"natural".

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental My important: If Item 27 is marked oth any injury or other traumatic event

Maryland 21215-0020

Baltimore,

Examiner

physician and the bunal-transit the.

Physician/Medical PV Completed Be

80 USB 10 8 funeral director. To Certification: 24 hours after death. Funeral Director: Af

certificate

After this

or Attending Physician:

Hospital

To the I

29a. Certifier (Check only one)

1 Naturel

2 Accident

3 Sulcide

4 Homicide

2 Medical Examinar: On the besis of examination end/or investigetion, in my opinion, daeth occurred at the time, data end placa, and due to the causa(s) end menner steted.

5 Pending

Investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Plece of Injury - At homa, ferm, street, factory, offica building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the bast of my knowledge, deeth occurred et tha time, dete end pleca, and due to tha causa(s) and manner as stated.

29b. Signeture end title of certifier Smult ben, mo

10/6941

mills md 21117

29c. License number

29d. Date signed (Month, Dey, Year)

30. Nama and addrass of person who complated causa of daeth (Item 23a) (Type, Print)

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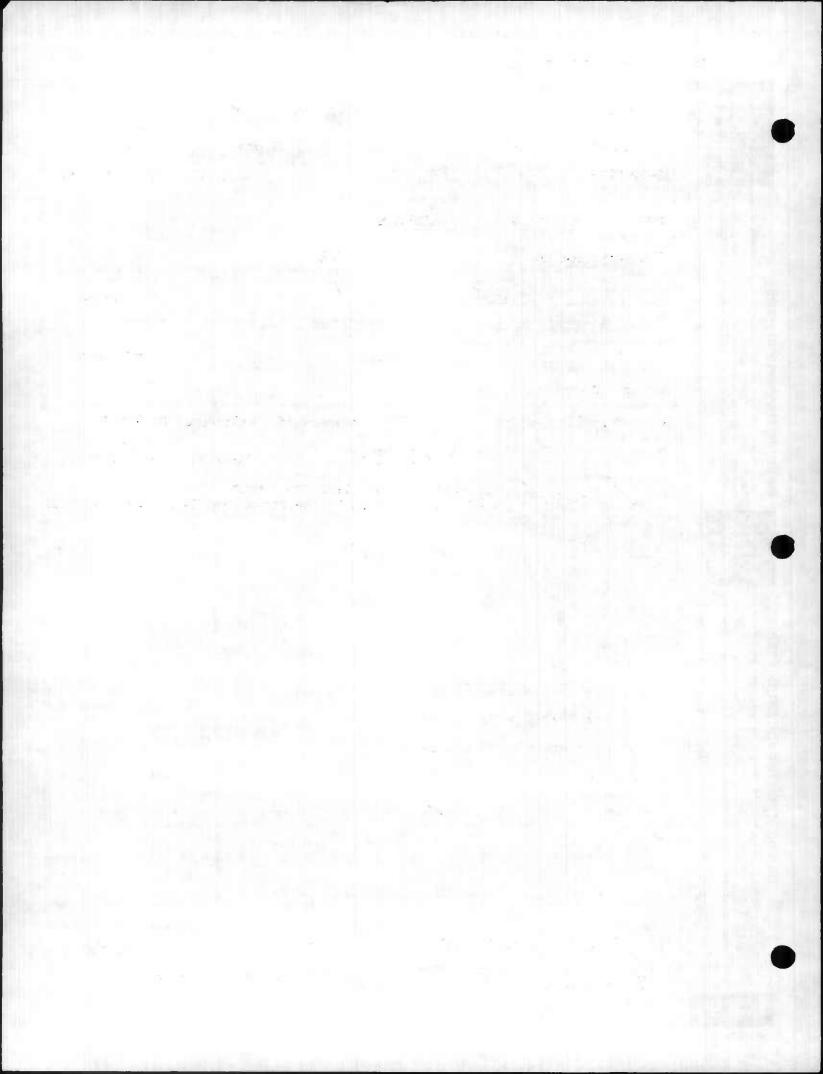
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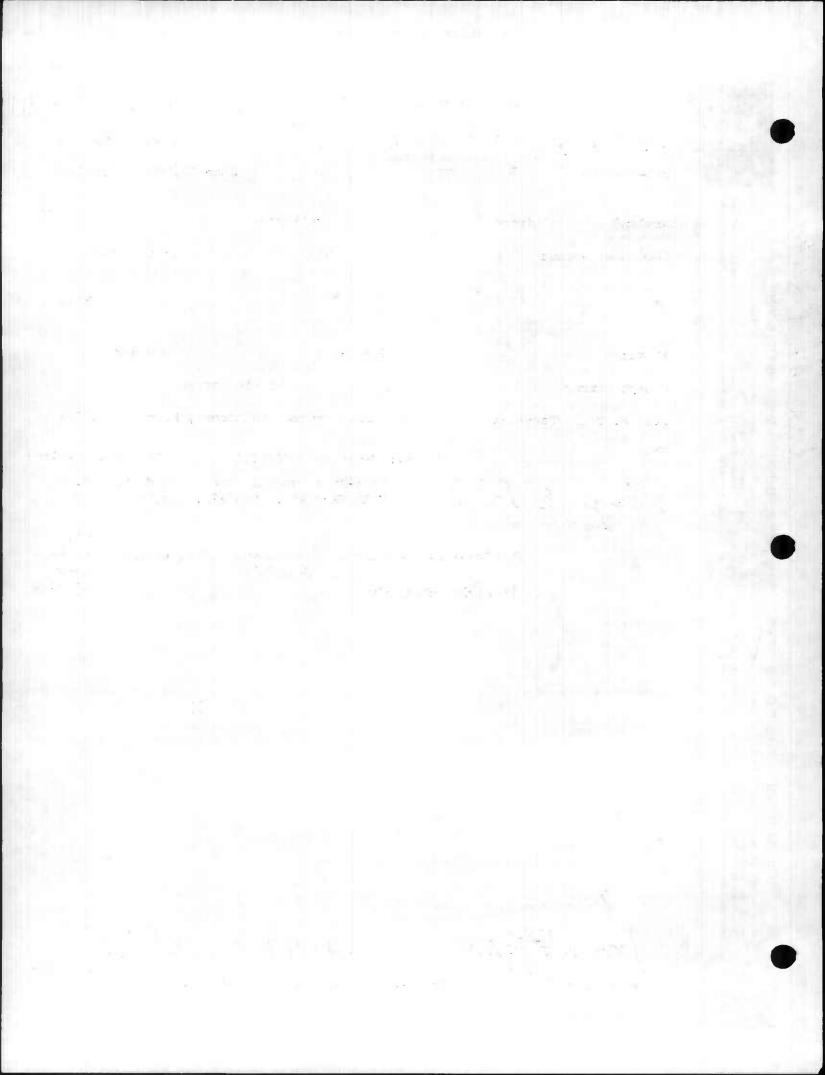
reha Burda



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Dorothy Frances Kendall 46 1 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, 4c County of Death Examiner OSEDAle 24aRe 0,401 HANKE 8. Data of Birth (Month, Day, Year) Time 22,1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign
Country) **Funeral** 1 □ M 2 € F Maryland Yrs. 213-30-6563 73 Director Usual Rasidanca of Dacadant Peges 1 and 2 should be filed within 72 hours after death with the Meryland nent of Health and Mental Hygiene. Int: If flem 27 is marked other than "natural", or flems 23a or 23e-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar Fault or notified at 1 ☐ Yas ¾ № No Director Baltimore Fullerton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 East Avenue 21206 United States Funeral 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Own Home Homemaker 10 Years 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Minnie Morgan Joseph Harron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) Baltimore, Maryland 5800 East Avenue Department of Health e important: If Item 27 is any injury or other traphose. Iris M. Kafka/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Mathod of Disposition Burial 2 Cremation 3 Removal from State 6/4/1998 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, the bit only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 1EARS ARTERIOSCLEROTIC CORONARY VASCULAR Examiner Due to (or as a consequence of): Examine HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that Initiated evants resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 edical Due to (or as a consequence of) The law requires that the death 23b. Did tobacco usa contributa to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? nis certificate has b 1 ☐ Yes 2 No l or Attending Physician: efter death. 25. Was case referred to madical examiner? Be 26. Place of Death (Chack only one) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yes 2 No Investigation Director: / 2 Accidant 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicida 24 hours eft • Funeral Di detely filled in 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifian Medical To the Complet To the To the To the 29b. Signature and title of cartifier 29c. Licansa number 29d. Date signed (Month, Day, Year) mo 30. Name and address of person with cause of death (Item 23a) (Type, Print) 21237 9101 FRANKLIN SQUARE OR. BALTIMORE MS 32. Registrar's Signature What Davidson—Randall 31. Date filed (Month, Day, Year) State JUN 0 3 1998 Registrar

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			Certificate of	Death	Reg	. No.		
Decedent's Neme (First, Middle, Las ALEXANDER	" LAWRE	NCE	JR.		2. Defe of Deeth MAY 28,	Day 1998		5:30A
4e. Fecility Neme (If not institution, give 5513 GERLAND				4b. City, Town, or L BALTII		4c. County o	N/a	
5. Sociel Security Number 220-24-9100 6. Security Number 11	7. Age	(In yrs. last bir	thday) If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Y	1931	9. Birthplace Country) MARYI	Stete or Foreign
Usuel Residence of Decedenf 10a. State 10b. County		10c. City, Tow	n or Location		1220			inside City Limits
MARYLAND N/	Α		BALTIMOR	E				1 Yes 2 No
10e. Street end Number 5513 GERLAND			10f. Zip Code	1206	10g	. Citizen of W	haf Counfry's	7
11. Meritel Stetus 1 Never Merrled 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give Year or Detea:		13. Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Spen, Mexicen, Puerto Specify:	ecify Yas or No- Rican, etc.)	Bieck	- American , White, efc.	
15. Decedent's Ed (Specify only highest gred	ucation	16a.	Decedent's Usuei Occup (Give kind of work done life. DO NOT use retire	during most of work	cing 16	b. Kind of Bus	iness/Indus	try
Elementary/Secondery (0-12) 12TH	Coilege (1-4or 5-			0)	В	ETHLE	HEM S	STEEL
17. Father's Neme (First, Middle, Last)	N/A	<i></i>	ABORER	18. Mother's Nem	e (First, Middle, Me	iden Sumeme))	
ALEXANDER LA	WRENCE,	SR.		BERNIC	E RYLES			
19e. informent's Name/Reletionship (7) DELORES LAWRENCE		19b 5.5	. Meiling Address (Street	end Number or Rui	BALTO, M	Ity or Town, \$	State, Zip Co 21206	de)
1X Buriel 2 Cremefion 3 1 4 Donetion 5 Other (Specify 21. Signefure of Funerel Service Licens 23e. Pert 1. Enter the disease, or compshock, or heart feliure. List only commediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that intieted events resulting in death) Lest Pert II. Other significant conditions co	e. Chronic Car d.	mt. Z	1412 E. nof enter the mode of dyling the consequence of): 202 Thy consequence of): consequence of):	PERY JUI	23b. Did toba 1 Yee 24e. Wes an eperforment	RAL H	OME MD. Aprint Or tribute to the 3 Probab 24b. Were availat compl of dee	21213 proximete ervel Between set end Deeth years years years e cause of death? fy 4 Unknown eutopsy findings be prior to elion of cause
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29b. Signeture and fifle of cuttier 30. Name and address of person who co	mediated cause of de	eth (item 23e) (29c. Licens Re	se number		Dete signed Y 28, MUYE, 1		. 63
Steven Dudek, 31. Dete filed (Month Day of sarrah	MD Ju	has t	loykins H	lospital	Baltin	nove, 1	Mary	land
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Introduction: If Item 27 is marked other than "natural; or Items 23s or 23s-f show any injury or other treumatic event, the Medical Examiner must be notified and page. Baltimore, Maryland 21215-0020 **Physiclan** /Medical Examiner Division of Vital Records, P.O. Box 6876 The law requires that the death cartificata has been signed by the a irector, page 2 should be datached

Physician

/Medical

Examiner

Funeral

Director

Directo

Funeral

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Physician/Medical Examiner

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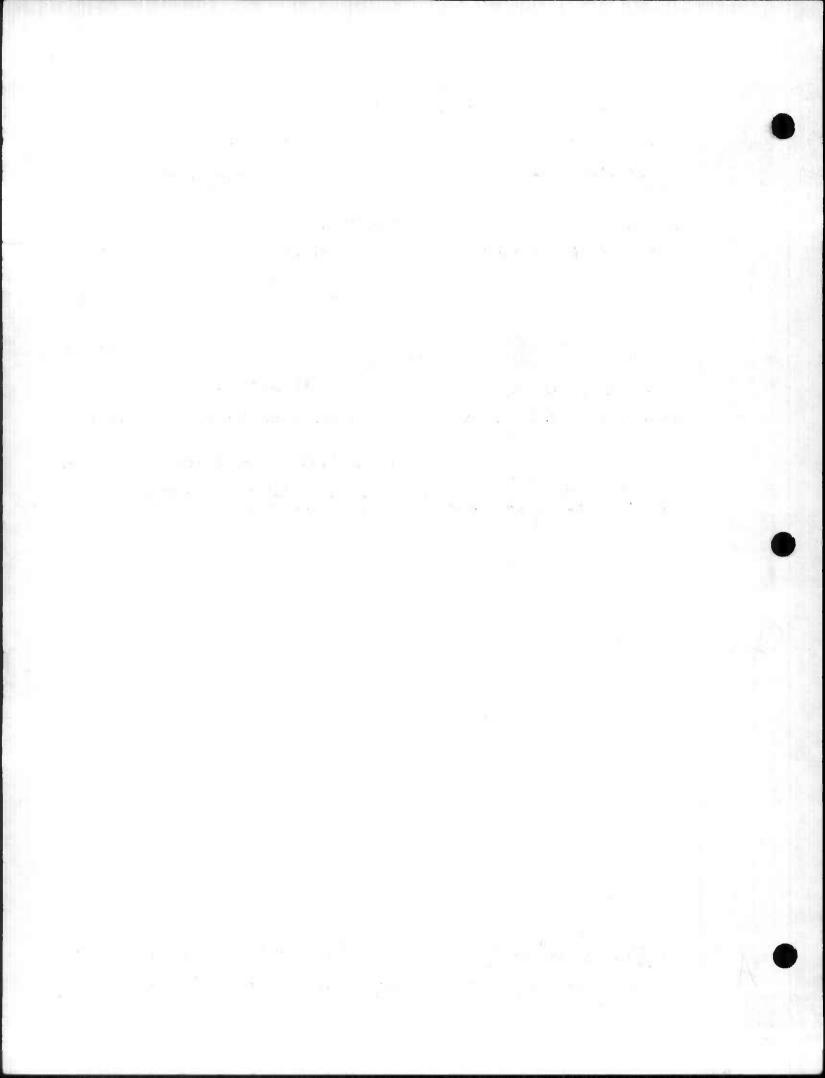
State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica

filled in by tha funeral

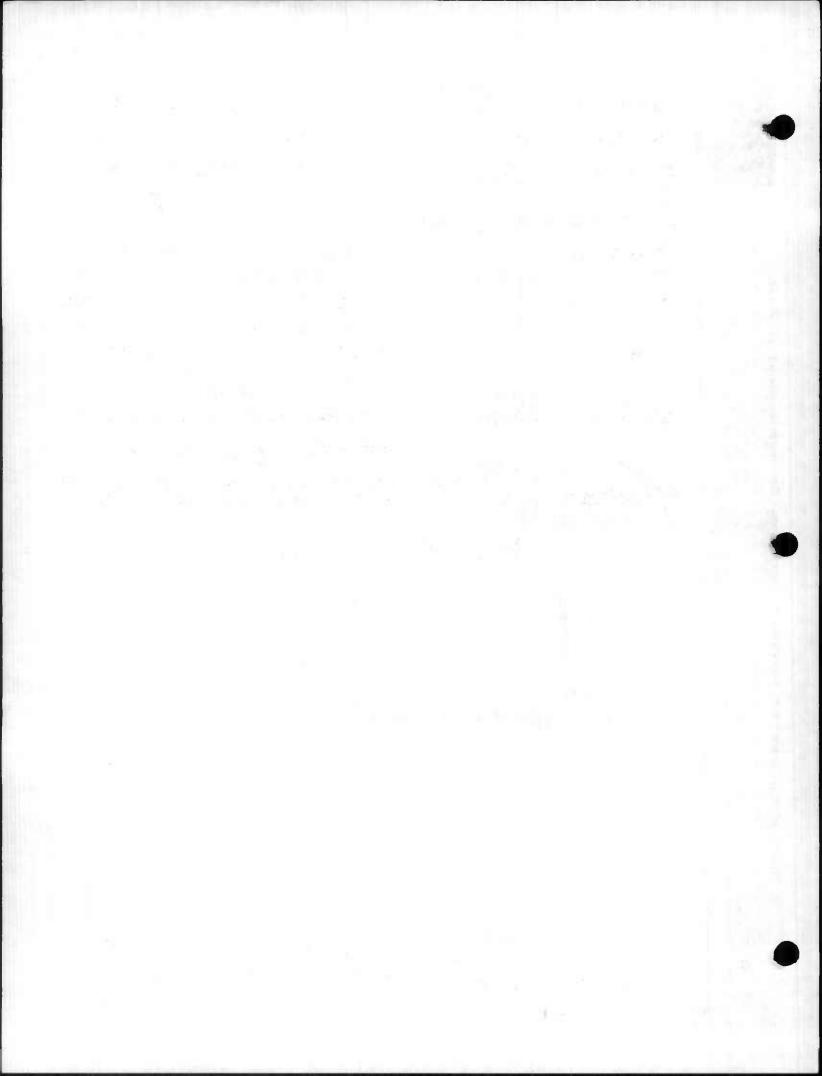
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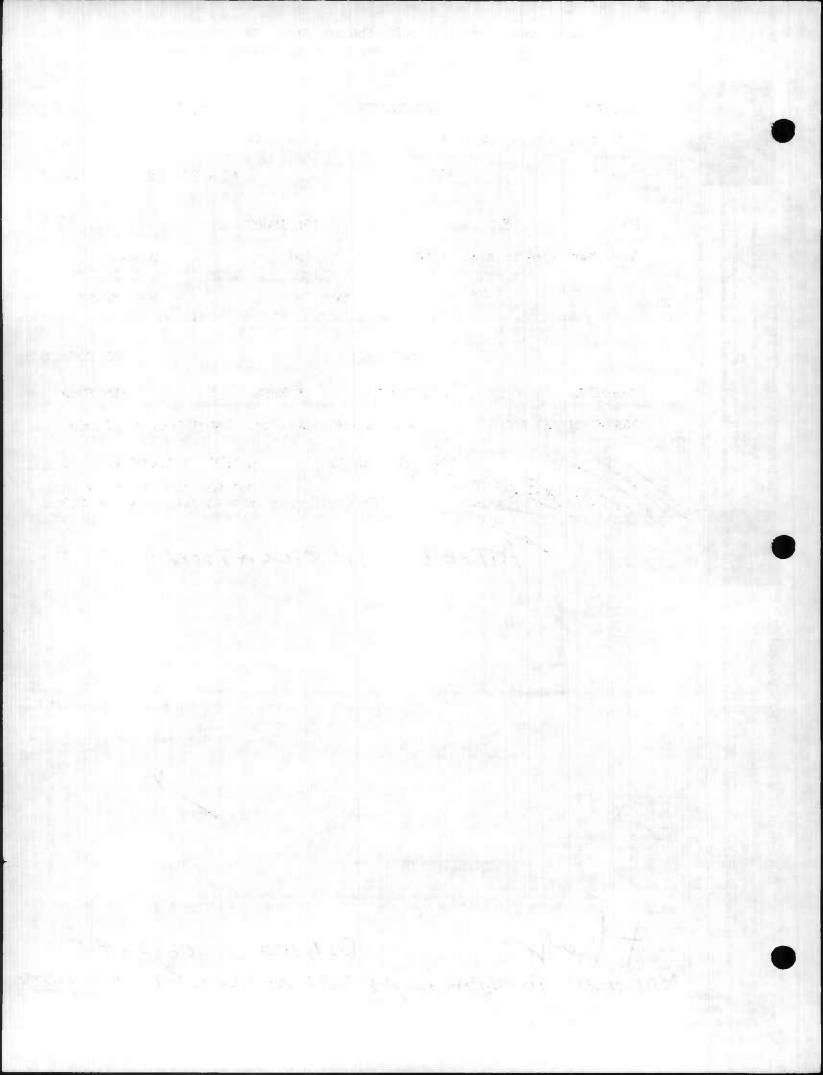
State of Maryland / Department of Health and Mental Hygiene

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Exami		4e. Fecility Neme (# no NORTH ARU			nber)			4b. City, Town, GLEN	BURNTE			of Deeth	DEL	
Funeral Director		5. Social Security Num 219-29-24 Usuel Residence of De	92	M 25%F	7. Age (In yrs. le 80	st birthday) Yrs.	If Under 1 Ye		Hrs. 8. Det	e of Birth pth. Day, Y 28,	917	9. Birthpl CHT	ece (Stete or Foreig	
with the Maryland a or 28a-f show	Director	10a. State 10	b. County ANNE ARU	INDEL		Town or Lo	VILLE						0d. Inside City Limite	
th with t	ai Dir	899 CECIL					10f. Zip Cod			10g	HONG		ry?	
within 72 hours after death ene. than "naturel", or therne 23	by Funeral	11. Maritel Stetus 1 ☐ Never Merried 3 🏿 Widowed 4 ☐	2 Married	12. Wes Dece Armed For 1 Tes If Yes, Giv Yeer or De	2 🐴 No e	1	Ves Decedent of Yes, specify O	of Hispenic Origin? Suben, Mexican, Po No Specify:	(Specify Yeuerto Rican, e	s or No- etc.)		e - America ck, White, e		
d 2 should be filed within 72 hours at the and Mentel Hygiene. T is marked other than "natural", or treumatic event, the Medical Expen	Completed	(Specify of Elementery/Seconder	. Decadent's Edu only highest gred ory (0-12)	cation e <i>completed)</i> College (1	-4or 5+)	(Give life. L	lent's Usuel Oc kind of work do DO NOT use rel	cupetion ne during most of lired)	working	16	b. Kind of Bi		ustry	
ould be filed of Mentel Hygie arked other attc event, to	Be	17. Fether's Neme (First	ach -	/ · · · A ·		18. Mother's Neme (First, Middle, Meiden St						umeme)		
	To	19e. Informent's Neme RACHEL L.	Reletionship (Ty	pe, Print) DAUGHT	ER	19b. Meilir 1107	g Address (Str	eet end Number of IGHAM DR.	Rurel Route GLEN	Number, C	ity or Town,	Stete, Zip 2 1 0 6 1	Code)	
10 mg 40 U		20e. Method of Disposi 1 Burial 2 X C 4 Donetion 5	remetion 3 🗆 R	emovel from S			sition (Neme of		6.22	98 BA	c. Location -	City or Tov	vn, Stete	
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Physician /Medical Examiner	er	23a Fart1. Enter the di shock, or heart fa Immediate Cause (Find disease or condition resulting in death)			rebre		1 mor	rhape					Interval Between Onset and Deeth	
requires that the death certificate be executed een signed by the attending physician again hould be detached for use as the burial-thrist	Medical Examiner	Sequentielly list condition of the sequentielly list condition of the sequence	ions, diate ng ry		Due to (or e	es e conseques e conseques								
that the daath cert ed by the attandin detached for use	Physician/	Pert II. Other significar	nt conditions con	tributing to de	ath but not result	ing in the ur	iderlying cause	given in Pert I.	23	b. Did toba	cco use co	ntribute to	the cause of death	
s that the gned by ti	y Phy	Art	eriosc	legat	icc	and	ae o	Uslass	2	1 🗆 Yee	2□ No	3 Prob	ably 4 Unknow	
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ysician: The law s certificate hes b director, page 2 s	Be Cor	25. Wes case referred exeminer?	to medical					26. Plece of	Deeth (Check	1 🗆 Yes	2 D No	1 🗆	Yes 2□ No	
Ing Physician: After this certific uneral director,	P	1 ☐ Yes 2 No 27. Menner of Deeth	Pending			R/Outpetien 8b. Time of Injury	28c. Ir	njury et Vork?	ng Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred)	
To the Hospital or Attending F within 24 hours after deeth. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident 3 Suicide 6 4 Homlolde	Investigetion Could not be determined	28e. Place buildin	of Injury - At hom g, etc. (Specify)	e, ferm, stre		Yes 2 No		ation (Street or Town, S		er or Rurel	Route Number,	
To the Hospital within 24 hours: To the Funeral completely filled	edical C	29e. Certifier 1 (Check only one) 2	Cartifying Phys Madical Examir	Iclan: To the later: On the barend menn	sis of exeminetic	edge, deeth n end/or inv	occurred et the estigation, in m	time, dete end ploy opinion, deeth o	ece, end due ccurred et the	to the cause time, dete	se(s) end me end placa,	enner es sta end due to	ited. the cause(s)	
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3		30. Neme and eddress	of person who co	/ 1	of deeth (Item 2	(3e) (Type, 1	77-6	3 Gar	mbri	lla	Rd.	Gar	mbrille	
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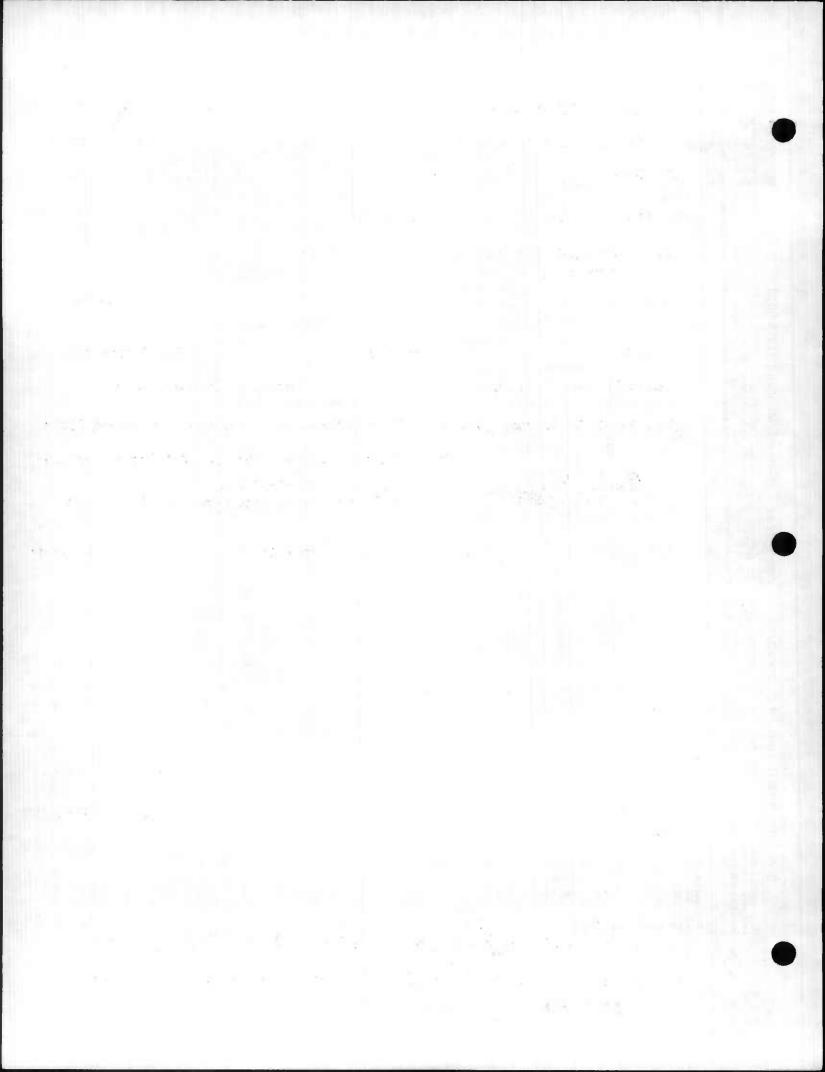


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** FREYDA MEZHERICHER MAY 31, 1998 6:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5715 PARK HEIGHTS AVE. #308 BALTIMORE N/A If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) 8. Data of Birth (Month, Dev. Year) **Funeral** Days Months Hours 1□ M 20 F Director 217-35-7629 100 AUG. 23, 1897 UKRAINE Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. inside City Limits 10a, State 10b. County ahow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 5715 PARK HEIGHTS AVE. #308 21215 U.S.A. Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritai Status filed within 72 hours after ☐ Yes 2☐ No Yes, Give X 1 Never Married 2 Married 1 ☐ Yes > NO Baltimore, Marviand 21215-0020 Specify: WHITE 2 XXWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 8 HOMEMAKER OWN HOME other 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Nama (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H OL IOS-SHMAY STINSNYDER **ESTHER** (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Relationship (Type, Print) JOSEPH RICHER (SON) 2726 MOORES VALLEY DR. BALTIMORE, MD 21209 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State important: It any injury o once. 6/2/98 REISTERSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW 22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Baltimore, MD 21208 the deam. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervei Between Onsat and Deeth shock or heart failure. List only **Physician** Immediate Cause (Finel disaese or condition resulting in death) /Medical IOU FIBRILLATION **Examiner** Examiner attending physician end for use as the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es a consequenca of): Box 68760 Physician/Medical Due to (or as a consequence of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by py Division of Vital Records. 24a. Wes an autopsy performed? 24b. Were eutopsy findings evallable prior to Completed completion of cause of death? certificata has 1 Yes 210No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No 28. Place of Deeth (Check only ong) Be Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 2 ER/Outpatient 3 DOA 1 Inpatiant this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: or Attanding 1 Naturel 5 Pending s efter death. 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide 24 hours Hospital edicai 29a. Certifier 1 Detrifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and menner stated. (Check only To the To the To the I 29c. License number 29d. Data signed (Month, Day, Yaar) 29b. Signatuly and till of certifier 124100 06-02-98 address of person who completed cause of deeth (Item 23a) (Type, Print) 30. Name and PRAISHALAR M.D. 21150 LD OREMS ROAD, BALTIMORE MADURA.L 31. Dete filed (Month, Day, Year) 32 Hougher Statute Mandalla State JUN 0 3 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

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Social Social Security Runbers 1.5 consist for Name 1.5 consists 1.5 consis	Examiner					4b. City, Town, or Li	ocation of Death		No. Day Year 1998 3. Time of Death 6:30 AM 4c. County of Death Baltimore County 9. Birthplaca (State or Foreign Country) 1937 Maryland 10d. Inside City Limits 1 Yes 2 No Citizen of What Country? USA 14. Race - American Indian, Black, White, atc. Specify: White 9. Kind of Business/Industry Own Residence den Sumama) 2th Ensor ity or Town, Stata, Zip Code) 2. Location - City or Town, State altimore, Maryland Maryland 21212 Approximata Interval Between Onset and Daath 2 Yess Coco use contribute to the cause of death? 2 No 3 Probably 4 Vunknown Sultopsy 24b. Were autopsy findings available prior to completion of causa			
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The State The County Too City Too Congress Too County Too Co		213-34-5689		Yrs Yrs	Months Days		8. Data of Birth (Month, Day, Nov 18,	Year) 9. 1937 M				
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A Docation S Division Scalar Mount Creamatory 6/4/98 Baltimore, Maryland 21. Signature Street St		Mrs. Bonnie L. I	Baltimo Date									
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Martin D. Sayson 6500 York Road, Reltimore, Maryland 21212 23a Part is the disease or complications that caused the death. Do not anise the mode of dying, such as cardisc or respiratory afraid. Approximate interval Between cheek and Death of the deat	it. Part rtant njury			Green M			6/4/98	Baltimore	e, Maryland			
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Immediate Cause (Final desires or condition seasing in death) Due to (or as a consequence of):		23a. Part1. Enter tha disease, or co shock, or haart failure. List on	mplications that cause y ona cause on each	ed the death. Do not line.	antar the moda of dyi	ng, such as cardiac	or respiratory arr	ast,	Approximata Interval Between			
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The state of the	in Triffice	25. Was casa rafarrad to medical				26. Place of Dea	th (Check only or	ne)				
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and placa, and due to the causa(s) and mannar as stated. (Check only one) 29b. Signature and interest certifier (Check only one) 29c. License number 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. R. Ly G-BMC 6701 M. Cherk (cs. St. Balt. M. 21204)	ysicii s cer direc		Hospital: 1 ☐ Inpat	ient 2 ER/Outpa	tient 3 DOA Ot	her: 4 Nursing H	ome 5 Raside	enca 8 Other (Specify) Hospica			
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and placa, and due to the causa(s) and mannar as stated. (Check only one) 29b. Signature and interest certifier (Check only one) 29c. License number 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. R. Ly G-BMC 6701 M. Cherk (cs. St. Balt. M. 21204)	ath. Aftar thise funeral	1 Natural 5 ☐ Panding 2 ☐ Accident invastigation	on (Month, D			ry at						
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	F 5 F 8) (A God	Long 11.	ley, mo	02	5205	5	Tune 1.	1998			
	5	30. Name and address of person wh	complated cause of	death (Item 23a) (Ty	pe, Print)	er les (+	Balt	MI 2	(204			
	State	31. Date filed (Month, Day, Year)	32. Figure	rar's Honelyre		- J	2-101					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** Vernon Hullmann Morgan 1998 3:27 May /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death **Examiner** Oak Crest Nursing Center Parkville Baltimore 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) March 2 1917 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Min Yrs. 81 219-01-7409 Maryland Director Usual Rasidance of Dacedant the Maryland 10c. City, Town or Location 10a. Steta 10b. County 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, on Medical Exercites roughly be notified as 1 ☐ Yas 2 No Maryland Baltimore Parkville Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mentel Hygiena. Important: If item 27 is merked other than "natural", or itema 23a or 2 any hiury or other traumatic event, the Mexical Exempter was been bottos. 8820 Walther Blvd. Suite 3313 21234 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 M Yas 2 □ No If Yas, Giva Yaar or Datas: WW II 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 18b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondery (0-12) Collega (1-4or 5+) Accountant Automobile 18. Mothar's Nama (First, Middla, Meiden Sumema) 17, Fathar's Nama (First, Middla, Last) Charles Edward Morgan Carrie C Hullmann 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Bruce C. Morgan/Son 9335 Oak White Road Baltimore, MD 21236 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 MOthar (Specify) entombment Dulaney Valley Mem. Gdns. 6-2-98 Timonium, Maryland 21. Signeture of Funeral Service Licanse 22. Nama and Addrass of Facility Mitchell-Wiedefeld Home, Inc. alle 6500 York Road Baltimore, MD 21212 onter the mode of dying, such as cardiac or respiratory errest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory erre shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in daeth) Examiner Physician/Medical Examine Fiber Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Diseasa or injury that initiated avants rasulting in daath) Last 2 MACTOG lobu Pinemin The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, Aldenstrom Dua to (or as a consequence of) nemin 980 signed by the a d be detached f Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown by 24b. Were eutopsy findings evallable prior to complation of cause of death? 24e. Wes an eutopsy performed? Completed After this certificate has funeral director, page 2 1 ☐ Yas 1 Tyas 2 No or Attending Physician: 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) HOS PICE Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 1 Natural 2 Accident 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding invastigation n 24 hours after death. • Funeral Director: Aft pletely filled in by the fur 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stata) 4 Homicida 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar To the Hosp within 24 hos To the Fune completely fi edicai (Check only one)

29c. Licansa number

29d. Date signad (Month, Day, Year)

State Registrar 29b. Signatura and titla of certifiar

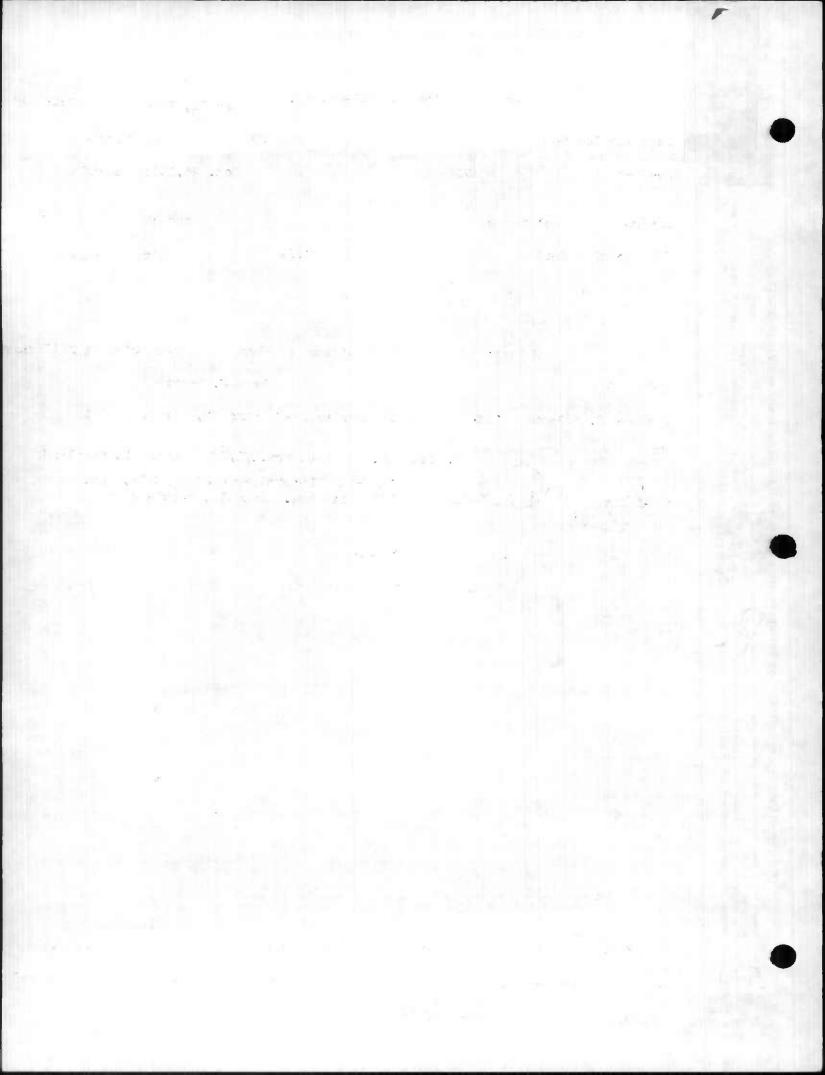
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300 Towson HOS Suha Navidon Randall 31. Deta filad (Month, Dey, Year) WN 0 3 1998

30. Nama and addrass of person who completed causa of deeth (Itam 23e) (Type, Print) R Ny mond

State of Maryland / Department of Health and Mental Hygiene

				Cei	rtificat	e of	Death			Reg. No.	.) (0 1	16	66	
Physician /Medical	Decedent's Name (First, Midd		ard 3	Joseph	Ne1	son,	Sr.		2. Date of De Month May 3:	eath Day		Year		of Death OO AM	
Examiner	4a Facility Name (If not institution 2228 Searles		umber)			4		wn, or Lo	cation of Deat	th 4c.	County of Balt	of Death timor	e		
Funeral Director	5. Social Security Number 535–28–1390	6. Sex 1⊠ M 2□ F	7. Age (In yrs. 72	iast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Do	th ay, Year) 24,19	925	Count	y) ylan	e or Foreign d	
Join be filed within 72 hours after death with the Marylend Mental Hydiona. When the Mydiona. When do the than "natural", or frame 23e or 28e-f show after avent, the Medical Examiner must be notified at the Medical Examiner must be notified at To Be Completed by Funeral Director.	Usual Residence of Decedent 10a. State 10b. County Maryland	Baltimor		ty, Town or Lo	ocation]	Dunda	alk	10		City Limits	
r thems 23s or 28s-4 s the man be not the funeral Director	10e. Street and Number 2228 Searles	Road			10f. Zip		21222					that Count			
at of Health and Mental Hygiene. If Rem 27 is marked other than "natural", or itsms 23a or 23a-f show or other traumatic avent, the Medical Examiner must be notified at or other traumatic avent, the Medical Examiner must be notified at or other traumatic avent, the Medical Examiner must be notified at other and the process of the contract of the co	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	Armed F	2 No WW	11	Was Deced If Yes, spec		lispenic Ori an, Mexican Specify:	gin? (Spe , Puerto	ocity Yes or No Rican, etc.)	0-		- America k, White, e			
her than "naturn nt, the Medical Completed		nt's Education est grade completed College 2 Yeal	(1-4or 5+)		dent's Usua kind of wo DO NOT us	rk done	during mos d)	of worki					siness/industry ffice& Military		
Mental Hygin british other atic avent, to To Be Co	17. Father's Name (First, Middle, John Nelson							r'a Name	(First, Middle			e)			
E	19a. Informent's Neme/Reletions Jensina G. Ne		Wife	222	8 Sea	rles	and Number	or or Rura	ndalk,	ber, City o	ylan	State, Zip o	Code) 1222		
Depertment of Health Important: If Item 27 is any Injury or other tre pncs.	20a. Method of Disposition *XXBurial 2 Cremation 4 Donation 5 Other (S			Placa of Disponentery, cred	matory or o	ther plan		em. 6,	Date /3/98	20c. Location - City or Town, State Dundalk, Maryland					
any in	21. Signature of Funeral Service	Licano	2						dome of				222		
hysician /Medical examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or had failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Due to (or as a consequence of):												Interval B Onset an	nd Death	
Medicai	Cause (Disease or infury that Initiated events that Initiated events resulting in deeth) Last Due to (or as a consequence of):														
ned by the attendi detached for use y Physician/I	Part II. Other eignificant conditi	ons contributing to	death but not res	sulting in the u	Inderlying o	ause gh	en in Part i			tobacco				oe of death?	
should be									24a. Wa	s an auto iormed?	opsy	ava	ore autops illable prion opletion of death?	sy findings or to of cause	
r, paga											X No	1□	Yes 2	No No	
tiel or Attending Physician; as fair death as fair death is sentification to the funeral director tied in by the funeral director Certification: To Be	25. Was case referred to medical examiner? 1 Yes Yes Yes Yes 27. Menner of Death 1 Yes Yes Yes 2 Accident Invest	Hospital: 1 [Inpetient 2 = te of tnjury onth, Dey Year)	28b. Time of Injury		28c. Inju	ner: 4 Nu	irsing Ho	me 5 Res 28d. Describe	idence		-)		
	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide deterr	nined 289. Mai	ce of Injury - At h Iding, etc. (Specil	(y)					28f. Location City or To	own, State	Θ)			umber,	
		ng Phyalcian: To the Examinar: On the end ma			vestigation	, In my c	pinion, des			, date an	d place, a	and due to	the caus		
To the	29b. Signature and title of cartific	louli r	72 Ph	٥	29		e number	4		29d. De	ate signed	d (Month, L	l q q	3	
1+1	30. Name and address of person	who completed ca			Print)	711	wa	, 14	57	BAI	していへ	ore,	Ma	21267	
State Registrar	31. Date filed (Month, Day, Yeer	Lilia	Registrar's Signa	fandelle											



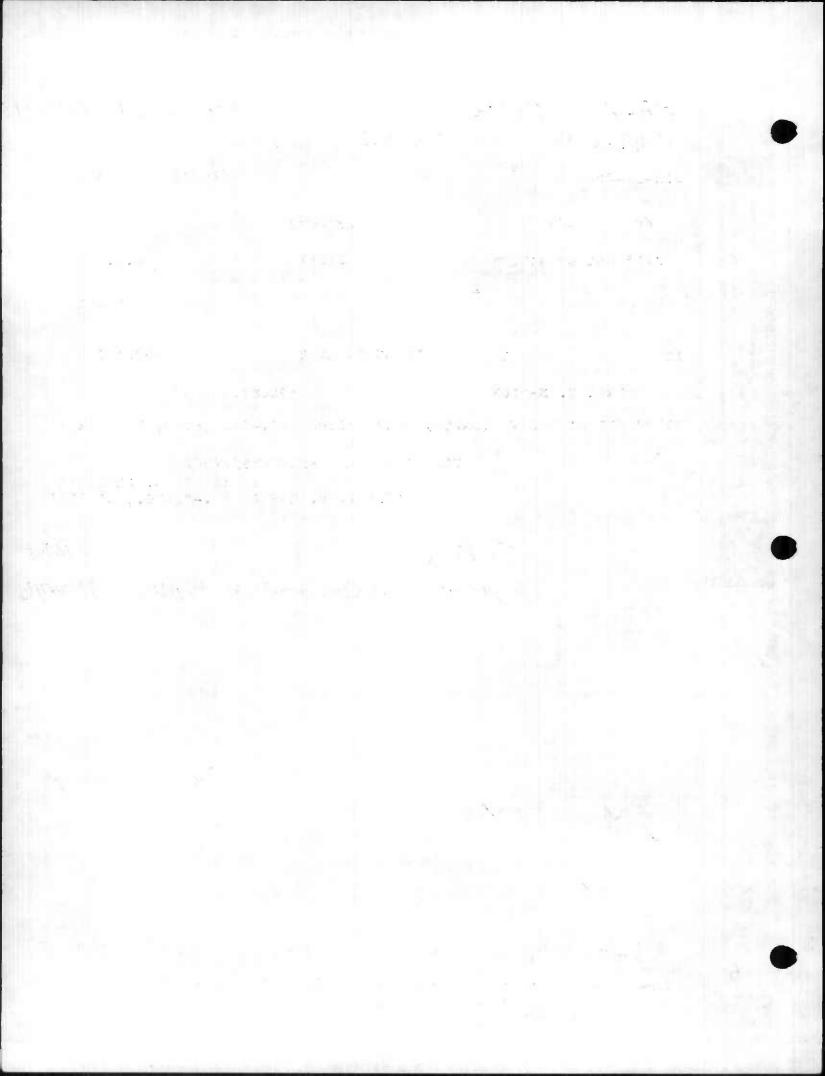
State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death 3. Tima of Death **Physician** ARYA 28 11 May /Medical 4b. City, Town, or Location of Oealh 4c. County of Death 4a Facility Nama (If not institution, giva street and number, Examiner ARBOR Baltimore HOS N/A If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days 1 M 2 F Yrs 61 MARYLAND Director 212-36-8500 Usual Residence of Dacedeni the Manyland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits f is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner trains be notified at 1 Nes 2 No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2113 BOLTON Funeral STREET 21217 U.S. 14. Raca - American Indian. filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 1 Yas 2 No Spacify: Specify: BLACK þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry complated) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. TEACHERS AIDE 12 EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be fund Mantal I is marked GEORGE E. MADDOX AUGUSTUS YOUNG permit. Pages 1 and 2 shou Department of Haath and Mi Important: If Item 27 Is mark any Injury or other traument 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHANIE WINCHESTER (DAUGH) 2113 BOLTON AVE.-BALTIMORE, MD 21217 Baltimore, 20b. Piaca of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dafe Burial 2 Cremation 3 Removal from State CATHEDRAL CEMETERY 6/3/98 DAL 70; MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servica Licanses 22. Name and Address of Facility ELIZABETH L. PHILLIPS 1721-27 N. MONROE ST.-BALTO., MD 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner MOLLS CELL CARCINOMA attending physician and for use as the burial-transit death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) ed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. that tha signed by t 1 ☐ Yee 2 ☐ No 3 Probably 4 DUnknown by requires 24b. Were autopsy findings available prior to should ! 24a. Was an autopsy Completed completion of cause of death? W. certificate has 2 🗆 No Division of Vital Physician: 25. Was casa refarred to medical examiner? Be 26. Piace of Death (Check only one) Hospitai: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 10 this funeral 28a. Dafa of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b Time of 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after daath.
To the Funeral Director: After it 5 Pending investigation 1 Yes 2 No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura and fitia of certifier Jargatha Leurlly HOUSE STAFF P10647 MAY 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 21225 MD 3001, S. HANOVER STREET BALTIMORE MURTHY SANGEETHA 32. Registar's Signature

Funa Daydoon ÜÜN 0 3 1998 State

DHMH 16 Rev 6/95

Registrar



Completed Be 2 Certification:

25

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was en eutopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death? Yes 2 No Yes 2□ No

. Was cese referred to medical				26. Pl	lece of Death (Ch	eck only one)	
examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 21	☐ ER/Outpatient	3□ DOA	Other: 4 🗆	Nursing Home	5 X Residence	6 ☐Other (Specify)
Menner of Death	28e. Dete of Injury (Month, Day Year)	28b. Time of	28c.	injury at Work?	28d.	Describe how inj	ury occurred

27 injury occurred investigation 1 ☐ Yes 2√√ No Unknown M found 5/26/98 Unknown 2 Accident 6)(X) Could not be determined 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1725 Montpelier St. Baltimore, MD.

MAY 27, 1998

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner steled. 29a, Certifier (Check only

29d. Date signed (Month, Day, Year) 29c. License number 29b. Sig turn and title of certifie

ress of person who completed cause of death (Item 23e) (Type, Print)

JUN 0 3 1998

DCKE MG 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year)

O.C.M.E.

State Registrar

edicai

32. Registrar's Signature

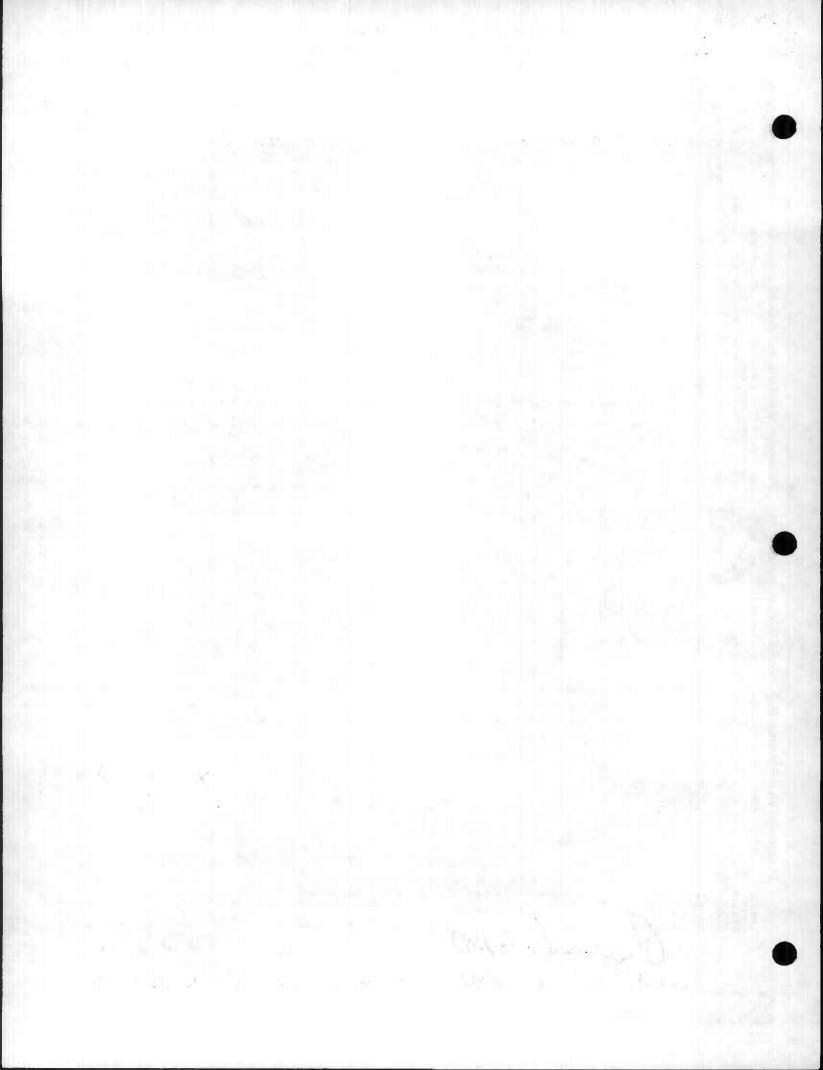
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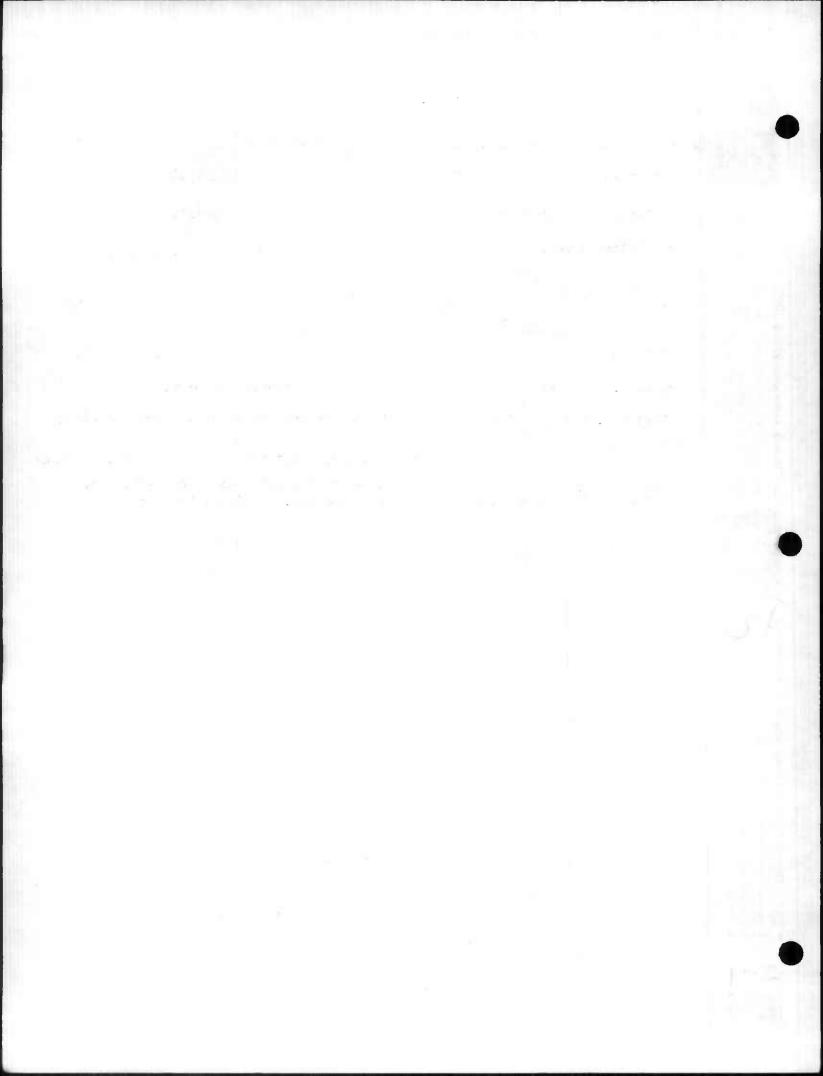
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To the Hospital or within 24 hours eff To the Funeral Di



State of Maryland / Department of Health and Mental Hygiene 98

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	dical	4e. Fecility Neme (If not institution, gi	ve street end number)			4b. City, Town, or I	May 2'	1	v of Deeth	2.33	
Exam	niner	Johns Hopkins Ba	201 1011110111011101	cal Ca	nter	Baltimor	e	4c. County	roi Deein	N/A	
Funer Directo			Sex 7. Age 1⊈M 2□ F	66 (In yrs. last bi	Yrs. If Under 1 Ye Months De		8. Dete of Bir (Month, De June	th by, Year) 10,1931	Cour	place (State or Foreign http) yland	
nyland show	L	10e. Stete 10b. County	21.	10c. City, Tov	vn or Location		D	a - 22-	1	10d. Inside City Limits	
the Marylar 28a-f show	Director	Maryland B	altimore		10f. Zip Cod	a .	Dun	dalk 10g. Citizen of	What Cour	1 ☐ Yes 2 🖺 No	
er death with Herns 23a or Inst. must be	rai Di	940 Dalton Aven	ue			2122	4	United			
O # 5 E	by Funeral	3 □ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Yeer or Dates:	lo	If Yes, specify C	of Hispenic Origin? (Spuben, Mexican, Puerto No Specify:	pecify Yes or No o Rican, etc.)		ca - Americ ck, White, y:		
15-002 n 72 hours "natural",	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16e	Decedent's Usuel Oct (Give kind of work do	ne during most of wor	king	16b. Kind of B	usiness/in	dustry	
212 I withir iena.	ошр	Elementery/Secondery (0-12) 8 Years	College (1-4or 5-		Fire Fight	•		Balt	imore	City	
nd nd legal Hyg	Be	17. Fether's Name (First, Middle, Las	1)			18. Mother's Nam		, Maiden Sumer			
Maryland 212: d 2 should be filed within the end Mental Hygiene. 7 is marked other then traumetic event, Inc. M.	2			T			ces Wis		1117-11		
E = N .		19a. Informent's Name/Reletionship Shirley F. Dels		ter 7	b. Meiling Address (Stre 402 Poplar	Avenue B		e, Mary	land	21224	
Baltimore, M emit. Peges 1 and 2 bepartment of Health mportant: If Item 27 is nny injury or other tra		20b. Method of Disposition 1 🖾 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) Oak Lawn Cemetery 6/1/1998 21. Signeture of Funerel Servica Licensee 22. Name and Address of Facility Duda—Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland									
	500										
		23a. Pert1. Enter the disease, or con shock, or heert feilure. List only	nplications that caused	the death. Do				-	Iu Z	1222 Approximete Intervel Between	
Physicia /Medica	il 📗	Immediate Ceuse (Final disease or condition			Caracan	Vasculas I	150000		1	Onset and Deeth	
Examine		resulting in death)			consequence of):	Varcolar L	ricale			years	
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Is, P.O. es that the de iigned by the abe detached	y Phy	Chronic Obstruct	ve Pulmona	y Disc	eore		10%	Yes 2□ No	3 Prof	bably 4 Unknow	
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f Vita yslcian: s certific director,	B	25. Was case referred to medical examiner?	11-24-1			26. Plece of Dee	th (Check only o	one)			
of Vita Physician: this certific	-T	1 No 2 No 2 No 27. Menner of Deeth	Hospital: 1 Inpatien		uthetieut 30 DOV			dence 6 Oth		y)	
ing ing	ation	1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Day	Year)	Time of 28c. In V	Vork? ☐ Yes 2 ☐ No	28d. Describe	how injury occur	rea		
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spits hours nersi	edicai C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysicien: To the best of miner: On the besis of e end menner stet	exemination en	e, deeth occurred at the nd/or investigation, in m	time, dete end plece, y oplnion, deeth occur	end due to the red et the time,	ceuse(s) end m date end plece,	enner es si end due to	teted. the ceuse(s)	
To the Ho within 24 I To the Fu completel	×	29b. Signeture end title of certifier	,		29c. Lice	ense number		29d. Dete signe	d (Month,	Dey, Year)	
		Noeds.	manle	1)	ı	28684		Hay 29,	1998		
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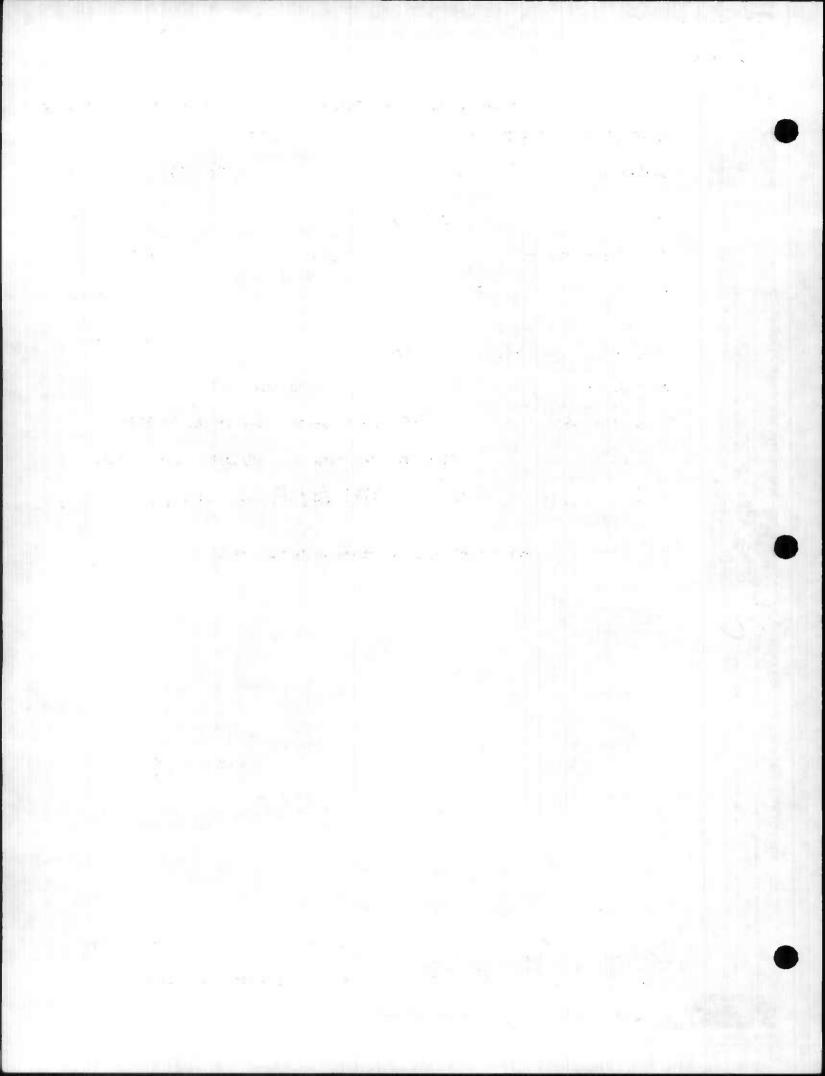
CHARITY PAIGE

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State of Maryland / Department of Health and Mental Hygiene 9

								Cei	niticate	or	Death			Reg. No			
	Physicia * /Medic	_	1. Decedent's Name (First, Midd			arit	y De	lphir	ne Pa				2. Date of D Month JUNE	Day	1998	ar O	Time of Death 146 AM
À	Examin	er	4a Facility Nama (If not institution ST.AGNES HOSE								BAL	LIMOR	cation of Dea RE	th 4c.	. County of D	eath	
	Funeral Director		5. Social Security Number 220–46–2887	6. Sex	M 21XF		(In yrs. las	st birthday) Yrs.	If Under 1 Months		If Undar Hours	24 Hrs. Min.	8. Data of B (Month, D 2-22-	irth 1945	9.	Birthplace Country)	(Steta or Foreig Md
	Manyland -f ahow	tor	Usual Residence of Decedent 10a. Stata 10b. County Md N/					Town or Lo								100	nside City Limit
	with the	i Direc	10e. Street and Number	Garde	n e				10f. Zip (ode 121	15			10g. Cit	izen of What	Country?	
020	urs a	by Funeral Director	11. Merital Status 1 🖄 Never Married 2 🗆 Mar 3 🗆 Widowed 4 🗅 Divorced	ried 12	. Wes De Armad f	Forces? 2 (X) No Bive	ivar in U,S.			nt of f	lispanic Or an, Mexica		ecify Yes or N Rican, atc.)	10-	14. Race - /	ace - Amarican Indian, ack, White, atc. ify: Black	
Baltimore, Maryland 21215-0020	I within piene. r than "	Completed	(Specify only higher Elementery/Secondary (0-12)	nt's Educa		(1-4or 5+		Decedent's Usual Occupation (Giva kind of work done during most of wolffle. DO NOT use retired) COOK				t of work	ing		ind of Busine uper P		y
land	tal H doth	To Be C	17. Father's Name (First, Middla Daniel J. Paig										(First, Middle t Well		Surname)		
, Mary	nit. Pages 1 and 2 should attract of the stand Mer offailt if Nem 27 is marked injury or other traumatic.		19a. Informant's Neme/Relation Chris Paige -		e, Print)				ng Addrass (al Routa Num 1 timor				(e)
imore			20a. Method of Disposition 1X) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) King Memorial Park 6/5/98 Randalls														
Balt	permit. Pag Department Important: I any Injury o		21. Signeture of Funeral Servica Licensee 22. Name end Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 212 23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												215		
4	Physician /Medical Examiner	ler	shock, or heart failure. Lis Immediate Cause (Final disaase or condition resulting in death)			rios			Cardio	vas	cular	Dis	ease				rval Between set and Death
5	F F9 = /	Examiner	Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury	b.		С	Due to (or a	is a consec	quence of):							I	
u	nding phy use as th	n/Medical	Ceuse (Diseese or injury that initieted events rasulting in death) Last	d.		D	ue to (or e	s a conseq	uenca of):								
P.O. B	5 6 0	Phy	Part II. Other significant conditi	ons contr	ibuting to	death but	t not resulti	ing in the u	nderlying ca	use gi	ven in Part	l.		tobacco		outs to the	cause of deati
Records,	he law requir te has been si age 2 should	Completed by											INSP	s en euto formed? ECTIC		compla of deet	utopsy findings le prior to tion of causa n?
of Vital	clan: ertific ector	Be	25. Wes case referred to medica examiner?	1								e of Deati	h (Check only	one)			
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	After fune	Certification:	27. Manner of Deeth 1 XX eturel 5 Pendi 2 Accident invest 3 Sulcide 6 Could	igation	(Mo	e of Injury onth, Dey	Year)	8b. Time o Injury	М	1	ryat irk?]Yes 2∐	No	28d. Describe			e Guest Go	uto Aliumbar
Ο̈́			4 ☐ Homicide determ	nined	buil	ding, etc.	(Specify)		reet, factory,					own, State	9)		
	To the Mospital within 24 hours To the Funeral completely filled	Medical	(Check only one)	Examine	r: On the		examinetion		vestigetion, i	n my	oplnion, dee		and due to th	o, date and	d place, and	due to the	cause(s)
	₽ ₹ ₽ 8		29b. Signature and title of cartific	M.	Ku	1-5	m)			.M.E				INE 1,		· ear/
	4		30. Name and eddrass of person Theodore King			use/of de	ath (Item 2			ree	t, Ba	ltim	ore, M	aryla	and 21:	201	
			31 Date filed (Month Dev Year)	324	Registra	r'e Signatur	70									

State Registrar 31. Date filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** RIGGS Month Irley 5:30 Am /Medical line 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner care timore 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 Deys Director 107-20-3292 May 16, 1927 Ohio Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified Director 1 ☐ Yes 2 No Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ទ items 23s 700 W. 40th St. 21211 USA death Funeral 12. Wes Decedent Ever In U,S Armed Forces? 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nest of Health and Mental Hygiene. Interfer than "natural", or the nry of other than "natural", or the ry or other traumatic avant, the Magical Energies rry or other traumatic avant, the Magical Energies 1 Never Merried 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by Specify. 3√2 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT use retirad) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) Secretary Clerical 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Sumame) Leo Sperling 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan Basik/daughter 1919 Old Court Rd. Towson, Md. 21204 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Department of H Important: If iter any injury or oth 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. 6/4/98 Towson, Md. 22. Name and Address of Fecility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Physician /Medical Immediate Ceusa (Finei disease or condition rasulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Diseese or injury that initiated avants resulting in death) Lest Due to (or es e consequance of) P.O. Box 68760, Due to (or as e consequance of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uea contribute to the cause of death? 1 Yee 2 10 3 ☐ Probably 4 ☐ Unknown STROKE Records, p 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Wes an autopsy performed? 1□ Yes No 1 Tes Division of Vital

Completed

Be 2

29a. Certifier

29b. Signature a

4 Certification: Alber or Attending death. after death To the Hospital within 24 hours a To the Fuheral C Medical

25. Wes casa raferred to medical 1 Yas 210 No 27. Mannar of Death

Netural 5 Pending Investigation 2 Accidant 6 Couid not be datarmined 3 Suicide

4 Homicide

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA

28a. Deta of Injury (Month, Day Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

26. Pleca of Daath (Chack only one) Other: Nursing Home 5 Residance 6 Other (Specify)

28d. Dascribe how Injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

rtifying Phyalcien: To the best of my knowledga, daath occurred et the time, data end plece, end due to the ceuse(s) and manner as stated. Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, data end piece, and due to the cause(s) and menner steted. 29c. License number 29d. Dete signed (Month, Dey, Year)

28c. Injury et Work?

31. Dete filed (Month, Dey, Year) JUN 0 3 1998

32. Registrar's Signature rulia Davidson

Registrar

State

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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 7 Per FH FilmG760 6-3-98 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** Kodgers 05.46 ar Carrie 1998 June /Medical 4e. Fecility Nema (If not institution, give street end number) 4b. City. Town, or Location of Death Baltimore
It Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Yeer) 4c. County of Death Examiner Medical Center Hunder 1 Year Bayview 6. Sex Johns Hopkins
5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1 M 2 F Deys 80 77 Yrs. 245-16-9970 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MA 1 Pres 2 □ No Director NA 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? USA 21229 407 K LENISON STREET Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yas 2 No
If Yes, Give
Year or Dates: 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Navar Marriad 2 Married 1 Yes 2 No Specify. Black þ Specify: 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) iatering Companies Jait RESS 1:2+K HURS. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) MAILLI Elder GRAHAM RIGHT 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ROAD BACTO MAZIZIS DEMETRIA RODGERS-DAUG. 3813 MIDHELEHTS 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete -3-98 Dalto. TETRO CREMATORA 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signeture of Funerel Sarvica Licensee TUDERAL HOME WEST, INC Jarch 4300 Wabash Are Salto md CODY Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onsat end Death Immediate Cause (Final hours diseese or condition resulting in deeth) Due to (or es e consequence of): so role mic Shock hours Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): arry thmia Atnal Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown disease 24b. Were autopsy findings evalleble prior to completion of causa of deeth? 24a. Was en autopsy performed? vascular disease ParioheraL 1 ¥ Yes 2 □ No 1 ☐ Yes 2 ☐ No tibrillation_ athal 25. Wes case referred to medical 26. Pleca of Deeth (Check only one) examiner? 1 ☑ Yas 2 ☐ No Hospital: 1 Manpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Menmer of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not ba determined 3 Suicide 4 Homicide

Examiner P.O. Box 68760 ed by the a been signed be should be detailed Records, certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i

Physician/Medical Examiner þ Completed Be Certification: To

Funeral

Director

28a-f show

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Нете 23а

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other treumatic event, the Medical Exercities once.

Physician /Medical

Baltimore, Maryland 21215-0020

death

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or invastigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated. 29c, License number

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signeture end title of certifier

97012

29d. Date signed (Month, Dev. Year) June

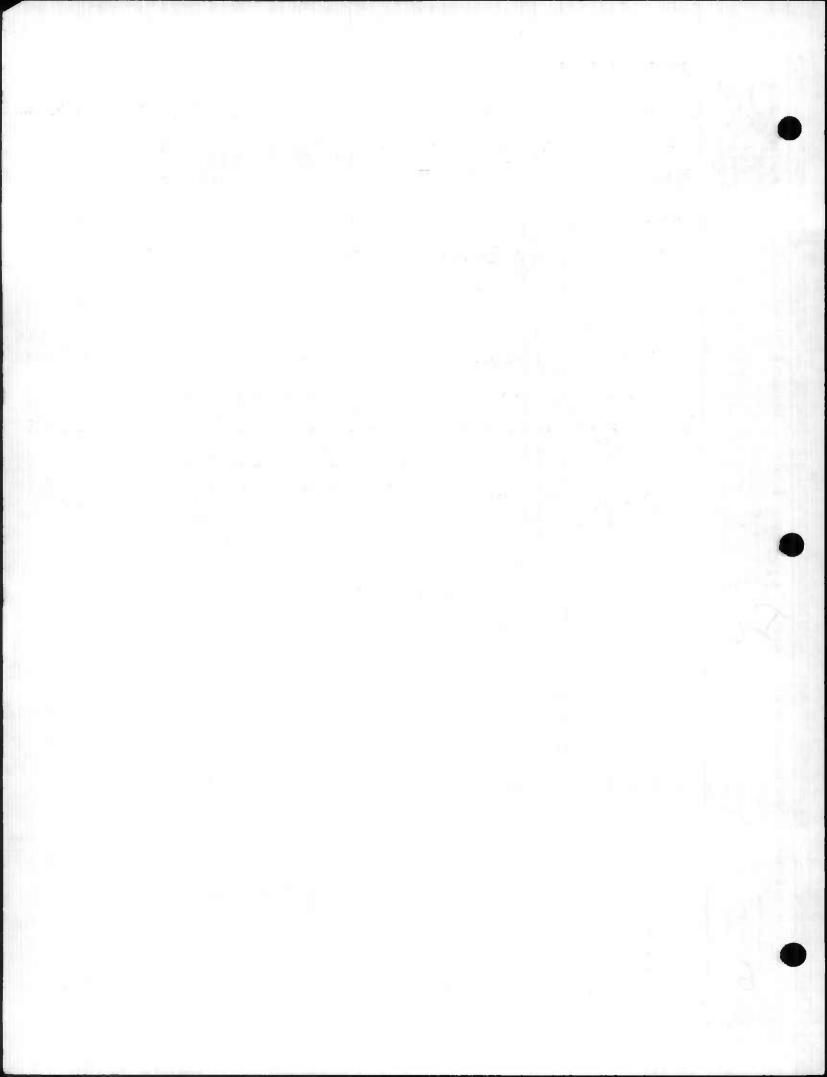
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Hopkins Bayview Medical Center Baltimore MD Johns

31. Dete filed (Month, Dey, Year) JUN 0 3 1998

29e. Certifier

32. Registrer's Signeture Alia Davidson

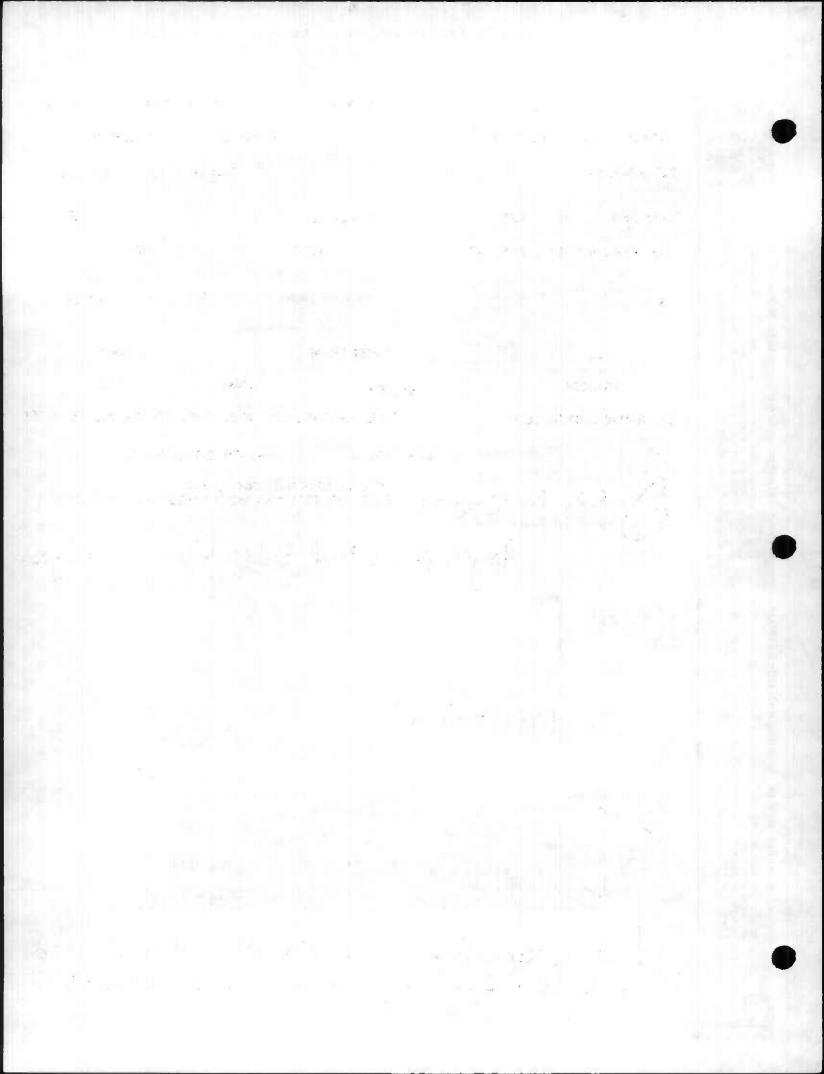


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** MAY 31, 1998 SHIRLEY RUTKIN 4:10am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Undar 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) AUG 28,1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 ☐ M 25 F Hours 77 215-18-5968 MARYLAND Director Usual Residence of Decedent with the Meryland 10a. State 10c. City. Town or Location 10d Insida City Limits 10b. County 7 is marked other than "natural", or hams 23s or 28s-f show traumatic event, the Medical Examiner must be notified at MARYLAND N/A BALTIMORE 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 7301 PARK HTS AVE, APT. 402 death v Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ ZZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 WHITE py 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) PROPRIETOR HARDWARE permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If flem 27 is marked oths any injury or other treumatic evant, phose. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JENNY** KITT **ISADORE** SNYDER 2 19b. Malling Address (Streat and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MR. BARRY RUTKIN (SON) 7301 PARK HEIGHTS AVE, APT. 402 BALTO, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH SHALOM 20a. Method of Disposition 20c. Location - City or Town, State 1XX urial 2 Cremation 3 Removal from State 6-2-98 TAYLORSVILLE, MD 4 ☐ Donation 5 ☐ Other (Spacify) 22. Name and Address of Facility
SOL LEVINSON & BROS., 21. Severatura of Funeral Service Licansaa INC. 6 8900 REISTERSTOWN ROAD BALTIMORE, MD 21208 ews 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, book, or mart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Amustrophic Immediate Cause (Finel 4eus disaase or condition resulting in deeth) Examiner as a consequence of): Due to (or Examiner attending physician and for use es the burial-tran Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events rasulting in death) Last Due to (or es e consequence of): death certificate be exec Box 68760. Physician/Medical Dua to (or as a consequenca of): USB 85 f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Presmonia 1 Tyes 2 Deto 3 Probably 4 Unknown 3 Records, þ 24b. Wera autopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy pertormed? Completed peed page 2 certificate has 1 ☐ Yes 2 ☐ No 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital Other: 4 Notising Homa 5 Residence 8 ☐ Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this uneral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Affer Certification: 5 Pending Investigation after death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Streat end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated. 29a. Certifier edical compietely (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of certifiar and cause of death (Item 23a) (Type, Print) 5310 Old Court Rd. 0 31. Dete filed (Month, Dey, Year) 2 Register's Signeture Tung Davidson-Andells

State Registrar

JUN 0 3 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Betty Bonniwell Upshur Rowley JUNE 1, 1998 17:50 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNES HOSPITAL 900 CATON AVENUE BALTIMORE If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 28 1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2 F 215-09-1655 80 Director Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Med cal Examiner must be notified at Md. Baltimore Co. Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4216 Kensington Road 21229 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or iter any injury or other traumetra. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0020 white þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Diamond Box Factory packer 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Clem Bonniwell Maggie Grinnalds 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Rowley Daughter in law 4216 Kensington Road Baltimore, Md. 21229 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 5 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 1998 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 22. Name and Acidess of Sacility
MCCully-Polyniak Funeral Home
130 E. Fort Ave. Baltimore, Md. 21230 21. Signature of Funeral Service Licensee 23a. Part1. Enter the diseasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medicai Immediate Cause (Final acute myocarrier Infarction diseasa or condition resulting in daath) 10 minutes Examiner Due to (or as a consequenca of) sician and burial-transit 10 years Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disaase or Injury that Initiated avants resulting in death) Last Due to (or as a consequence of) physician (s the burial-P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown Chronic obstructive lung disease 1 ☐ Yee 2 ☐ No Records, 24b. Wera autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? HISTORY LUNG CARCINOMA - RESECTED SCLERODERMA 1 Yes 20 No 1 Yes 2 No Division of Vital 25. Was case rafarrad to medical examiner?

1 Yas 2 No 26. Place of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Death Certification: 28a. Data of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 Panding investigation 1 Natural To the Hospital or Attandile within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Sulcide 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifias 29b. Signatura and titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year)

D 226 Y8

900 S. CATONAYENUE BATIMORE, MARKAND 21229

State Registrar 30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)

Name and address of person who compressions.

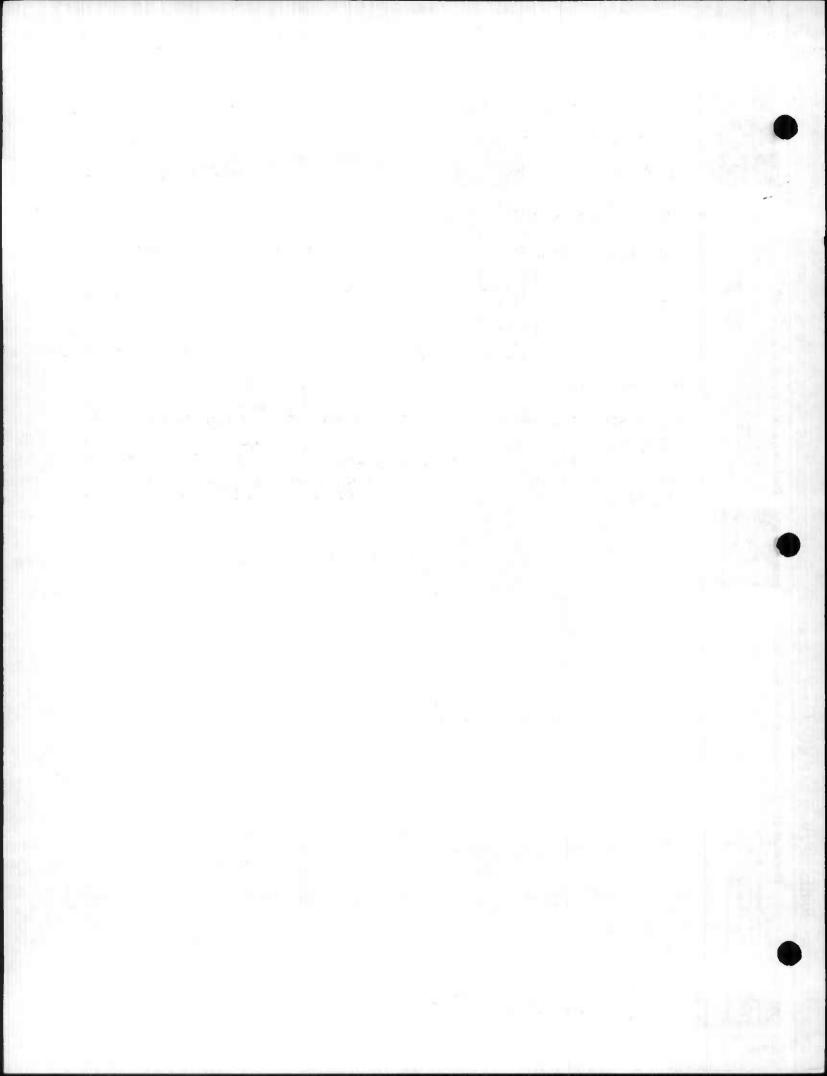
Teromo I Sny der m. D. 900 3

Jerome JUN 0 3 1998

BET.

ROWLEY

AME



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth SHIRLEY STOVER June 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore If Under 24 Hrs. 8. 5. Social Security Number NLA If Under 1 Year 9. Birthplece (State or Foreign Deys 1 M 2 F UNKNOWN Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No NIA MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 550 STREET USA. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ 100 If Yes, Give Yeer or Dates: 14. Race - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No 3 ₩idowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 8 +++ G-RAOE College (1-4or 5+) HOMEMAKER OWN 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) BRADFORD JAMES 19e. Informent's Name/Retetionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) OLIVIA THOMAS SISTER) 612 W. LAFAYETTE AVE., BALTIMORE, MD. 21217 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cremation 3 □ Removel from State ZION CEMETERY 4 Donetion 5 Other (Specify) 21. Signature to Funeral Service License 22. Name and Address of Facility of SEPH H. 2140 N. Fuz BROWN FULTON AVE. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory effect shock, or heart feilure. List only one cause on each line. . Renal tailure / hepatic metastases Immediete Ceuse (Fine) disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of) Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Miknown 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 MInpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medicai Examiner ettending physician end for use as the burial-transit

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

ortant: If Itam 27 is marked other then "natural", or items 23a or 28a-f show Injury or other traumatic event, the Mosical Examiner must be notified at

filed within 72 hours efter Hygiene.

permit. Peges 1 and 2 should be filed within 72 hours Depertment of Health end Mentel Hygiene. Important: If Itam 27 is marked other then "natural", any injury or other traumatic event, the Mexical Example of the Mexical Example

altimore, Maryland 21215-0020

Physiclan/Medicai Completed by Be Medicai Certification: To

The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, signed by the page 2 s certificate To the Hospital or Attending Physician: within 24 hours efter death.

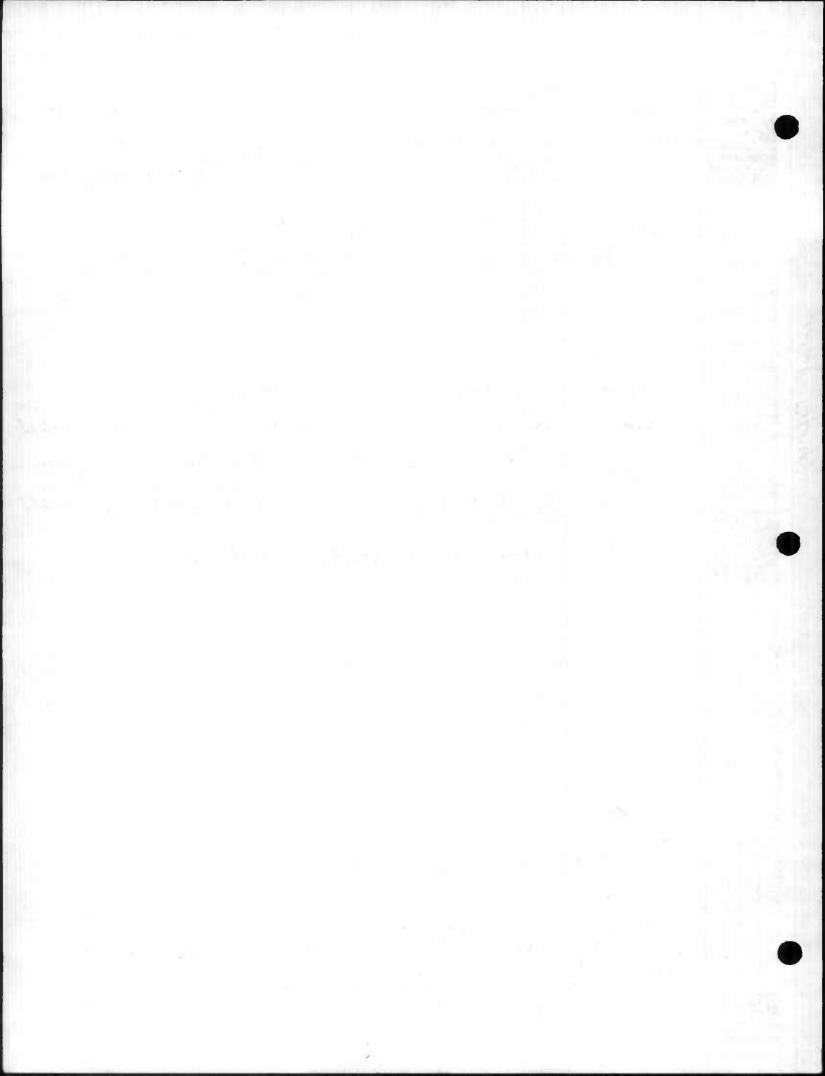
To the Funeral Director: After this certifica completely filled in by the funeral director, p.

State Registrar

25. Was case referred to medical 1 Yes 2 No 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier 29c. License number 29b. Signeture and title of certif 29d. Dete signed (Month, Day, Year) General Hospital

Nostata, M.D. 32. Regist 31. Dete filed (Month, Day, Year) JUN 0 3 1998



Physician

/Medical

Examiner

1. Decedent'a Name (First, Middle, Last)

4a Facility Name (If not institution, giva street and number)

ARUNDEL

HOSTITAL

Matilda Ida Snyder

NORTH

Funeral Director	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. 213–03–2395 1 M 3 F 85 Yrs. Months Days Hours Min.	Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) Waryland
A how	Usual Rasidanca of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne-Arundel Glen Burnie, Maryland	10d. Inside City Limit
A 80 H 7	10e. Street and Number 32 Chester Circle 11. Marlial Status 1	10g. Citizen of What Country? United States
121215-0 121215-0 led within 72 hr lygiena. Per then "natur nt, the led cell	300 Widowed Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 12th Grade N/A Homemaker 17. Fathar'a Name (First, Middla, Last) 18. Mother's Name (First, Mid	16b. Kind of Businass/Industry Own Home First, Middle, Meiden Sumeme)
Manualth an auth an artrau	19a. Informant's Name/Relationship (Type, Print) Loretta E. Larkin / Daughter 19b. Mailing Address (Street end Number or Rural R 32 Chester Circle, Glen Bur	mie Maryland 21060
Baltimore, permit. Pages 1 a Department of Hee Important: If New any Injury or othe pince.	Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Camatery, crematory or other plece) Holy Cross Cametery June 5, 19	Date 20c, Location - City or Town, Stata Paltimore Maryland
Ball Ball Ball Ball Ball Ball Ball Ball	21. Signature of Funeral Sarvice LicanseeVictor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral 1501 Fast Fort Avenue, Ball 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	timore Maryland 21230
/Medical Examiner	Immediate Cause (Final disease or condition rasulting in death) a. ACUTE MIDCAR DIAL INTO Due to (or as a consequence of):	FARCTION SEVEN HE
X 6876(certificata be ding physicia se as the bur		
. 0 00		23b. Did tobacco use contribute to the cause of deat
Il Records, The law requires the law requires the law requires the last been signed page 2 should be of Completed by	DITUES TO THE PARTY OF	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death?
n of Vitc ng Physician: fter this certific meral director	25. Was case referred to medical examiner? 1	1 Yes 2 No 1 Yes 2 No Check only one) 5 Residence 6 Other (Specify) 1. Describe how Injury occurred
Division (teal or Attending P are after death. rat Director: After t lied in by the funer.	3 Sulcide determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	Location (Straet end Number or Rurel Route Number, City or Town, Stete)
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the t	E 29b. Signature and title of certifian 29c. License number	due to the cause(s) and manner as atated. at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Dey, Year) TUNE 01 1998
	30. Name and address of person, who completed cause of death (Item 23a) Type, Print SVDHIR K. AGG NRTH ARUNDEL HUSPITAL, 301 HUSPITAL DRIVE, GLE	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Assure Ail Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death Month

10

JUNE

BURNIE

4b. City, Town, or Location of Death

COLEN

3. Time of Death

RUNDEL

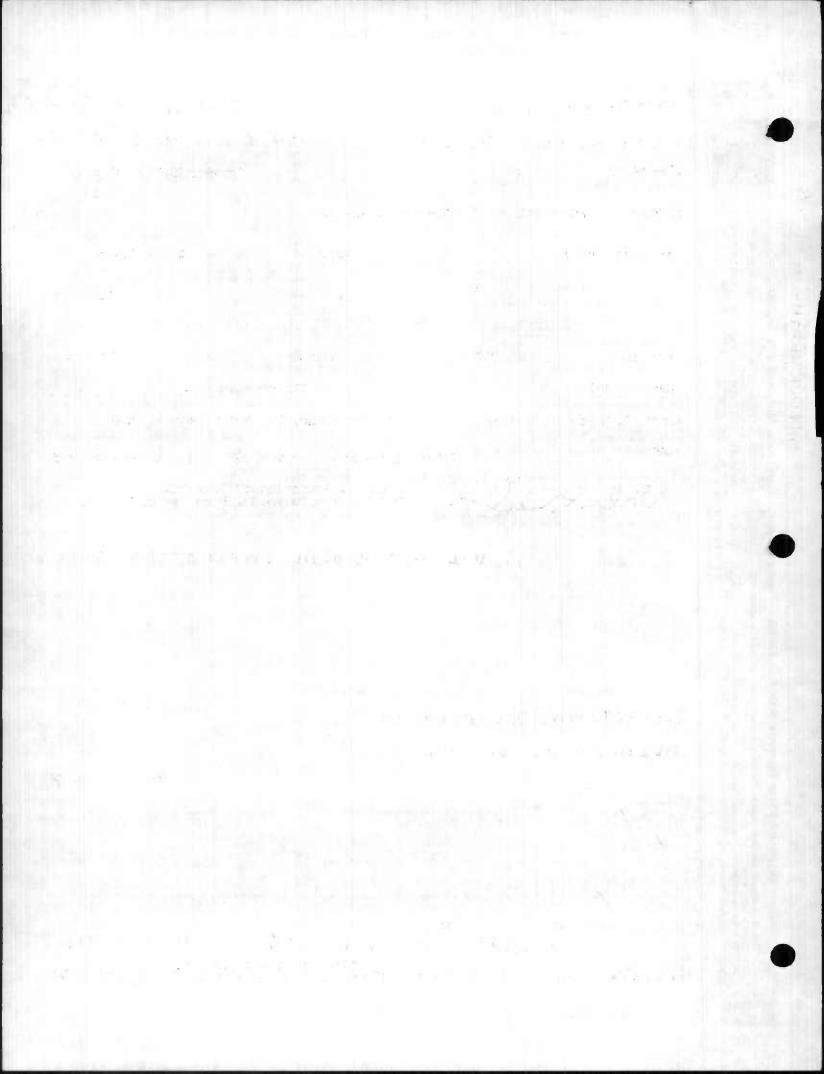
9. Birthplace (State or Foreign

3-08 Pm

Year 1998

4c. County of Deal

ANNE

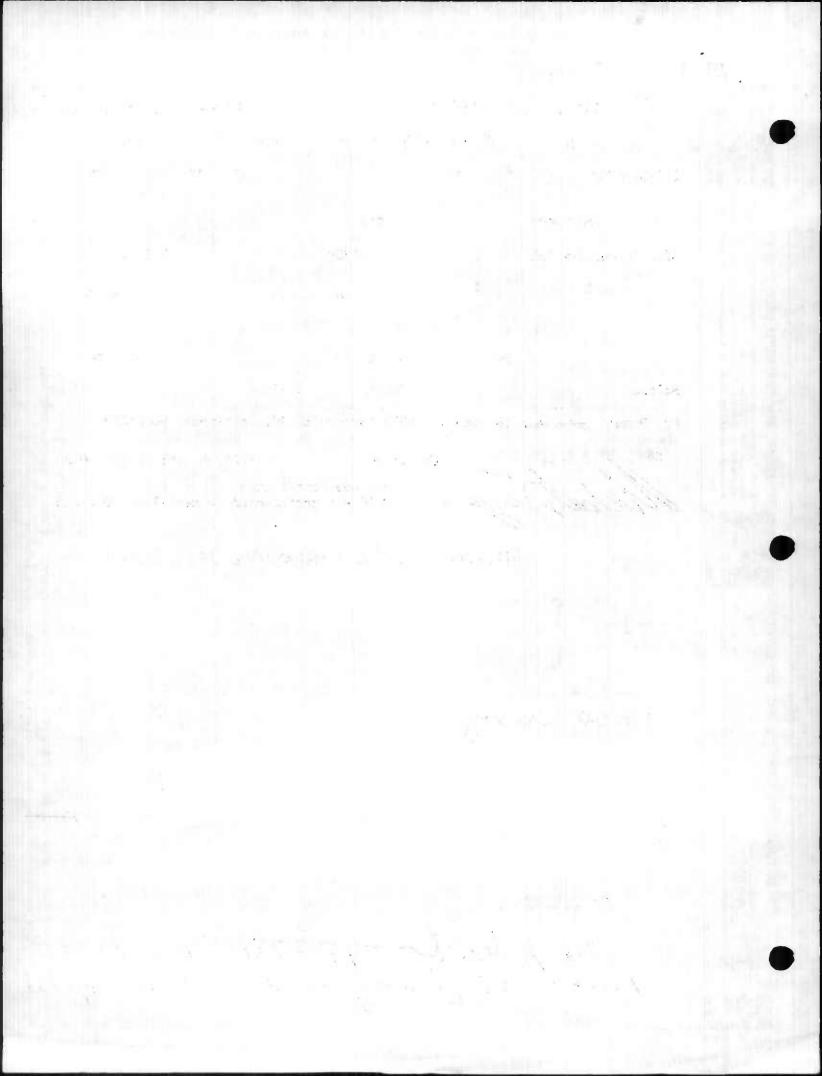


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM #19a per Phy G760 6/3/98 EW Item#26 perPhy G760 6/3/98 EW Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedant's Name (First, Middle, Last) Month **Physician** Smulliar sara Eva c IAL 1998 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** System Emergency Ctr BALTIMORE Health N/A Sinm If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Hours 1□M 21XF Months Days Min 58 PA 30 **Director** 160-32-3760 Usual Rasidance of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Haaith and Mental Hygiana. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 1 Yas 2 No Baltimore Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21209 6512 Gardenwick Rd. U.S.A. Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Married White 1 Yas 2 No altimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5+ Nurse Medicine 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Cohen Soloman Julia Minsk 19a. Informant's Name/Ralationship (Type, Print)
Mr. Ronald Smullain (Husband) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 6512 Gardenwick Rd. Baltimore, MD 21209 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 Burlal 2 Cramation 3 Ramovel from Stata 4 Donation 5 Other (Specify) 5/25/98 MD Beth Tfiloh Baltimore 22. Nama and Addrass of Facility
Sol Levinson & Bros 8900 Reisterstown Rd. Pikesville, MD 21208 Approximata Interval Batween Onsat and Death 23a. Part f. Entar tha disaasa, or complications in a causad tha death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition resulting in daath) /Medical CARDIOU ASCULARS Examiner Due to (or as e consequança of) Examiner attanding physician and for use as the burial-transit law requires that the death certificate be executed Sequentially list conditions, it any, leeding to immadiate cause. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco usa contributs to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 XNO 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed page 2 s certificate has 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) axaminar Hospitai: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) To 3 DOA 15 Yas 2 No 1 Inpatiant 2 ER/Outpatient this 27. Mennar of Death funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t Certification: 1 Neturel 2 Accident 5 Panding invastigation 1 ☐ Yas 2 ☐ No death. after death Director: 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 29a. Cartifian 🕰 Cartifying Physician: To tha best of my knowladga, death occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. Medical within 24 hor To the Fune completely fi (Check only one) 2 Madical Examiner: On the besis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titia of certifia 30. Nama and address of person who completed cause 32. Registre s Signa 31. Data filad (Month, Day, Yaar) State

DHMH 16 Rev 6/95

Registrar

JUN 0 4 1998



		State of Marylai		tificate of			eg. No.	8 17	234	
Physiciar /Medica	DONOTHI PANIE DE					2. Date of Deat Month JUNE	Day 2,	Veer		
Examine	An Carith, blama His and Inglibution also				4b. City, Town, or L GLEN BU					
Funeral Director	5. Social Security Number 6. S 1 212-01-6645		:. last birthdey) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Dey, MARCH 8	Year)	9. Birthplace (S Country)	Stete or Foreign	
Marylend a-f show	Usual Residence of Decedent 10e. State 10b. County MD ANNE A		ity, Town or Lo							
with the Mar	10e. Street and Number			10f. Zip Code		1				
15-0020 72 hours efter death with the Maryland *naturel; or thems 23s or 28s-f show exical Examiner must be notified a	1233 CEDARCLIFT 11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give		210 Vas Decedent of H Yes, specify Cub ☐ Yes X☐ No	Hispenic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		1998 7:00A.M. Founty of Deeth NNE ARUNDEL 9. Birthplace (State or Fore Country) 20 MARYLAND 10d. Inside City Lim 1 Yes 2 1 1 9. Birthplace (State or Fore Country) In of Whet Country? S. A. 1. Raca - American Indian, Black, White, etc. 1. Specify: WHITE 1. Ind of Business/Industry ARTMENT STORE 1. Indian State ARTMENT STORE 1. Indian State Interval Between Conset and Death 1. Indian State 1. In		
21215-0020 di within 72 hours efi glene. In then 'naturel', or in Moderal Escription		Yeer or Detes:	16a. Deced	ent's Usual Occup	petion during most of world)	king	16b. Kind of Br			
212 3 within glene. r than	Elementary/Secondary (0-12) 11TH GRADE	College (1-4or 5+)		SEAMSTRES			DEPART	MENT ST	ORE	
yland 2 ould be filed Mentel Hygic arked other attic event, u	17. Father's Name (First, Middle, Last)						, <i>Malden Sum</i> eme) WOLLENHORST			
Mar nd 2 sh nd 2 sh ith end 27 is m	19a. Informant's Name/Relationship (MARY HARE (DAUGH	Type, Print)			end Number or Ru	ral Route Number	, City or Town,	Stete, Zip Code)		
of Herrory	20a. Method of Disposition 1 ☑ Burlel 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific	Removel from State	cemetery, cren	sition (Name of natory or other pla EDERAL CI		Date 06/04/98			ate	
Baltimoperant. Peg Department traportant: I sany Injury operant: I sany I sa	21. Signature of Funeral Service Licer		HU	Name and Addre	oss of Facility JNERAL HO	ME INC.				
Physician /Medical Examiner	23a. Part : Enter the disease, or come shock, or heart failure. List only immediate Cause (Finel disease or condition resulting in death)	a. CHRONIC O	ath. Do not ent	TIVE	ng, such as cardiac	or respiratory arm	est,	Appro Interv Onse	al Between t and Death	
68760	Cause (Diseese or Injury that initiated events resulting In death) Lest	c	(or as a conseq or es e conseq							
death certific at the attendir		d								
s that the death certificate by the attendire be deteched for use	Part II. Other eignificant conditions of	- 1:	sulting In the u	nderlying cause gi	ven in Part I.		obacco uae co			
aw requir	Dysphapen, 1	weight live				24a. Wes e	med?	available completic of deeth?	prior to on of cause	
f Vital Ryysicien: The Is certificete he director, page				T _a		1 ☐ Yo		1 LJ Yes	2 No	
Ing Ph After thi funeral	1 Yes 2 ONo	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	_	ome 5 Reside				
Division tal or Attending setter death. all Director: After led in by the func	3 Sulcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		eet, factory, office		28f. Location (Si City or Town		per or Rural Rout	a Number,	
To the Hospital within 24 hours To the Funeral completely filled		ysician: To the best of my kn niner: On the besis of examin and manner stated.							ause(s)	
within To the compl				29c. Licen	se number	2	9d. Date signs	d (Month, Dey, Y	'ear)	

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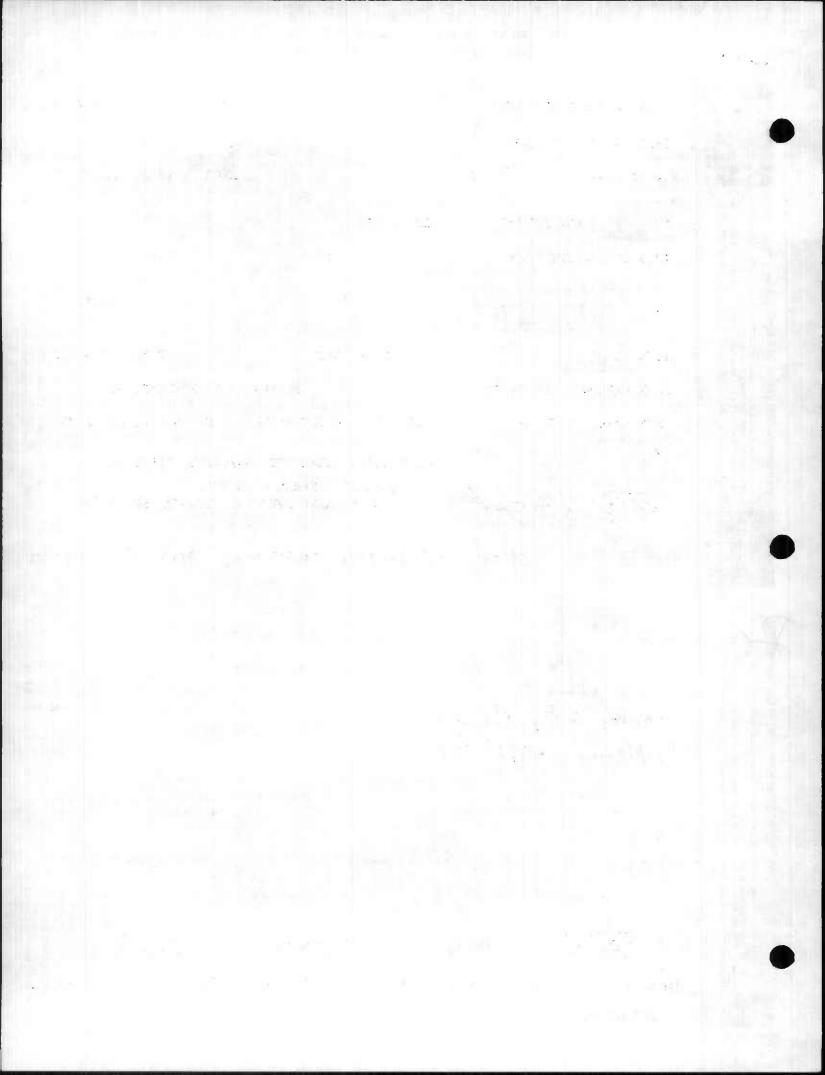
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALTEET SINGH SIDHU 1413 ANNAPOLIS ADAD #106 ODENTON MD21113

31. Date filed (Month, Dey, Year)

JUN 0 3 1998

State Registrar



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** HYMAN SANDERS MAY 27 1998 9:40 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 31 STONEHENGE CIRCLE, APT. 2 BALTIMORE 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 8 8 Yrs Director 295-09-7776 MAR. 24, 1910 RUSSIA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD BALTIMORE BALTIMORE 1 Yas X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 STONEHENGE CIR., APT. 2 21208 USA Funeral death 14. Raca - Amarican Indian, Black, White, atc. 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 5+ REPORTER COURT 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 1 and 2 should be fi Health and Mental H em 27 Is merked ou SAMUEL SANDERS GOLDENBERG SARAH LENA 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If item 27 is any injury or other traughts. BALTO., MD 21208 MOLLIE SANDERS (WIFE) 31 STONEHENGE CIR., APT. 2 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 \ Burial 2 Cramation 3 Removal from State
4 Donation 5 Other (Specify) 6/2/98 HAR SINAI OWINGS MILLS, MD SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final MELANMA disaasa or condition resulting in death) **Examiner** Due to (or es a consequence of): Physician/Medical Examiner the death certificate be executed burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician as the Due to (or as a consequenca of) use ed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown signed by 4 metro C+ TtC Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 212NO 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 10 1 Yes 0 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Nospital or Attanding PI 24 hours after death. Funeral Director: After the Certification: 5 Pending Investigation Maturel Injury 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number NIN

ed cause of deeth (Item 23a) (Type, Print)

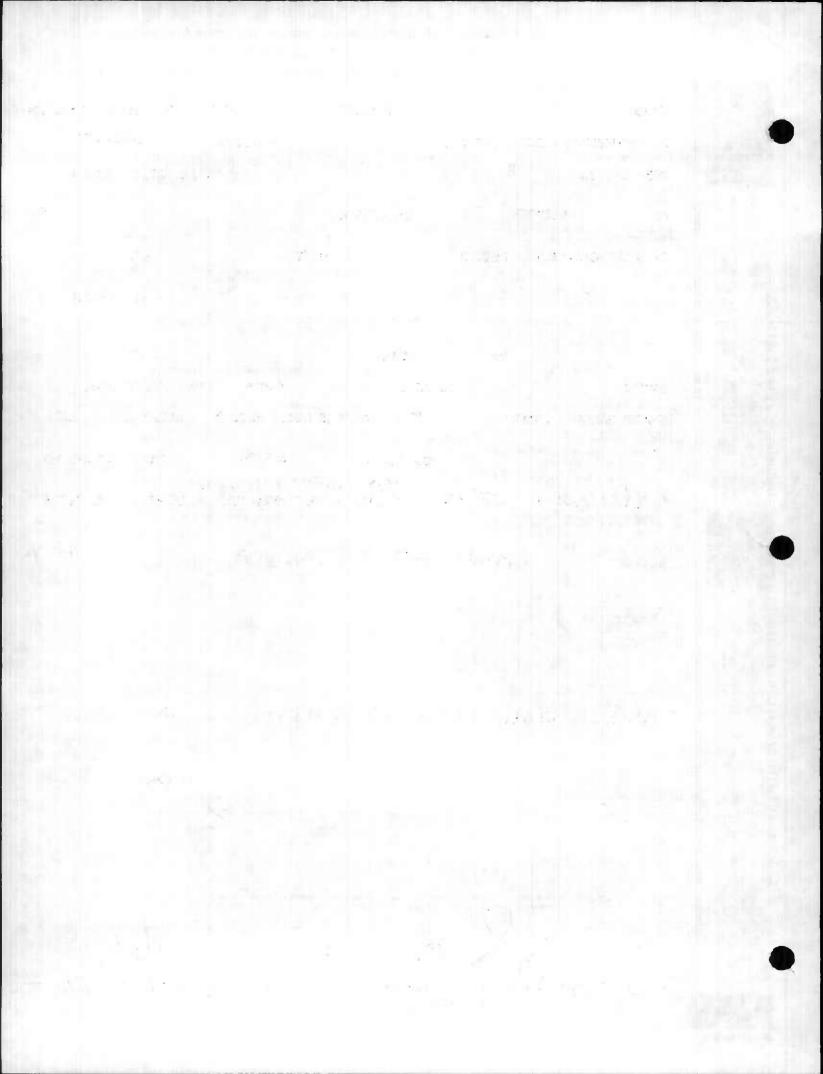
1 Crossroads

0

Drive 415 Owings Mills

State Registrar 30. Neme and address of person who c

31. Date filed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 17236

			Ce	rtificate of	f Death		Reg. No.		1230
Physician Medical	Decedent's Name (First, Middle, Last CYNTHIA A		ERMAN			2. Date of Dec Month May 29	Day	Year	3. Time of Death
Examiner	4a Facility Name (If not institution, give FRANKLINS SQUARE				ESS		4c. County BALTI		
Funeral Director			yrs. last birthday) 43 Yrs.	If Under 1 Yea Months Day		8. Date of Birt Month, Da SEPT.	^h 19,19	9. Birthple Count 4 MZ	ace (Stata or Foreigr ry) ARYLAND
death with the Maryland rms 23e or 28e-f show creat De notified at	Usual Residence of Decedent 10a. State 10b. County MARYLAND N	/A 10	c. City, Town or Lo					10	od. Inside City Limits
offer death with the Ma offer death with the Ma offer must be not the funeral Director	10e. Street and Number 21 MOPEC CIR	CLE APT.	С.	10f. Zip Code 212				zen of What Country?	
ours effer el', or its Evaning		12. Was Decedent Ever Armed Forcas? 1 Yes 2 No If Yes, Give Yaar or Datas:		Was Decedant of if Yas, specify Cu 1 ☐ Yes 2 ☑ N	Hispanic Origin? (ban, Mexican, Pue o Specify:	Specify Yas or No rto Rican, atc.)	- 14. Rac Blac Specify	e - Amarican Indian, ck, White, etc.	
within 72 sne. than "nate molete	15. Decedent's Edi (Specify only highast grad Elementary/Secondary (0-12) 12TH	cation (a completed) College (1-4or 5+) N/A	(Give	dent's Usual Occ kind of work don DO NOT use reti BUS DF	e during most of wo red)	orking	MASS ASSOC	TRAN	
Maryland 2 d 2 should be filled th and Mental Hygie traumatic event, if	GEORGE	JACKSON			18. Mother's Na	ED THO			
P.O. Box 68760 at the death certified a wacund by the death certified a wacund by the attention and positive as the companied for use as the companies of the	20a. Method of Disposition 1	Removal from Stata lee lications that causad the na causa on aach lina a. Due c. Dua	to (or as a consect to (or a)	particle (Name of malory or other p N FORES Name and Add CALVIN 1412 E partial mode of d quence of):	lace) JUN ST VETER Iress of Facility B. SCR L. PREST lying, such as cardia	E 4, 19 ANS CEM UGGS FU ON ST. ac or respiratory at	998 Location 998 No. OWIN	GS M HOME MD.	ILLS, MI
cords, requires to been signe should be distant by						24a. Was	Yes 2 □ No an autopsy med?	24b. Wa ava cor	ra autopsy tindings illable prior to npletion of cause
Vital Recipion The law certificate has metor, page 2	25. Was case reterred to medical examiner?					1 100 eath (Check only o	Yas 2 No		peath? DYes 2□ No
on of ting Phys Attentitis funeral di	XXI as 2 140	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ya) 28e. Placa of Injury building, etc. (S	At homa, farm, st	f 28c. In W	jury at /ork? □ Yes 2 □ No		how injury occur	red	
Divisit To the Hospital or Attent within 24 hours after deat to the Funeral Director: completely filled in by the Medical Certifical	29a Cartifiar 1 Cartifying Phy	aician: To the best of m nar: On the basis of exa and manner stated.	mination and/or in	n occurred at tha vestigation, In my	tima, date and place y opinion, daath occ	ca, and due to tha curred at tha time,	causa(s) and ma data and place,	innar as st and due to	ated. the causa(s)
To the comp	29b. Signature and title of penifier	- A		0.C	.M.E.		29d. Date signe May 30,		Day, Year)
	30. Name and districts of person who c	omplated causa of death	111 Per	n Stree	t, Baltim	ore, Mar	yland 2	1201	
State Registrar	31. Date tiled (Month, Day, Year) JUN 0 3 1998								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amend: #23a Part Ib Per MD Film G760 6-3-98RC 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Month Year **Physician** May 12:01am 30 1998 Marcus Edward Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Severna Park

If Under 24 Hrs. 8. Date of Birth

Under 8 Min. (Month, Dey, Year)

Feb. 7, 19 Examiner 10 Luna Lane Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 1X M 2 F Yrs. 220-07-8395 Director Maryland Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show show 1 Yes 2 No Directo Anne Arundel Severna Park 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 and of Health Hygiene. Int: If ferm 27 is marked other than "natural; or flerm 23a or 3 and 10 or other traumatic event, the Modical Examine, must be any or other traumatic event, the Modical Examine, must be an any or other traumatic event, the Modical Examine. 10 Luna Lane 21146 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 125 Yes 2 □ No If Yes, Give Year or Dates. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Maritel Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner-Operator Marketing Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcus Duke Smith Mabel Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tracents. Marcus Edward Copeland-Smith 1707 Bayside Drive, Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 06/01Baltimore, MD 22. Name and Address of Fecility Hardesty Funeral Home, P.A 12 Ridgely Ave. Annapolis, 21. Signature of Funeral Service Licenses MD 21401 ala 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence ot): Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): es P.O. Box 68760. physicilin s the buria 0 4 Physician/Medicai that initiated events resulting in death) Last Due to (or a a consequenca of): The law requires that the death certificate 98 use 0 signed by the a 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? been signal 24a. Was an autopsy performed? Completed has cartificata ha 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home ome 55 Residence 6 Other (Specify)
28d. Describe how Injury occurred 2 1 ☐ Yes 2 No 3 DOA 1 Inpatient 2 ER/Outpatient this funeral 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After or Attending 5 Pending investigation 1 Naturel 2 Accident death. 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rurei Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide

in 24 hour.
The Funeral Direction of Tilled in by Hospitai To the Vithin 2

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completely

awes 31. Date tiled (Month Day, Year) 98

29b. Sonature end title of certiful

29s. Certifier

30. Name and

Check only datus?

edical

State Registrar

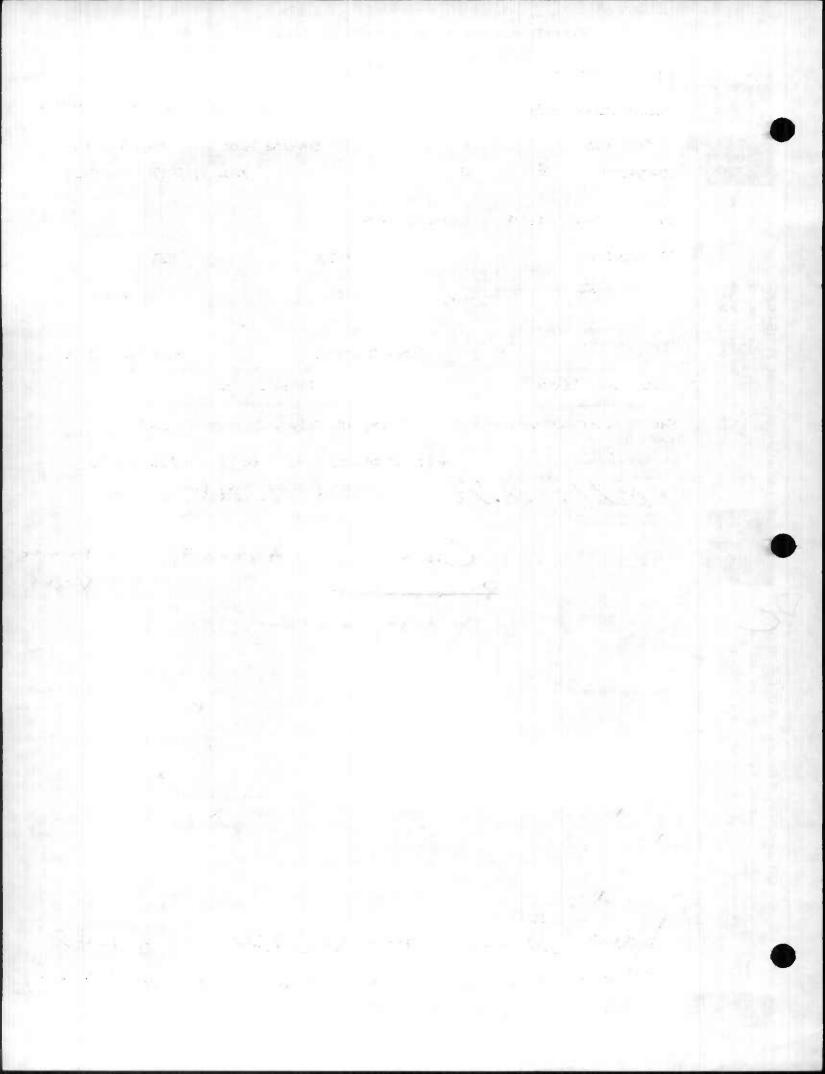
O sha Pojetrar Signature

ddress of person who completed cause of death (Item 23e) (Type, Print)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

17238

Physicia	_	I NE ESUIV					SANDERS			2. Date of L Month	Day 3	Yaar 1999	3. T th
/Medica Examine			If not institution, giv					·	4b. City, Town, BALTIN	or Location of Dea	th 4c. County	1.0	
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or 28	Director	10e. Street and Nu					10f. Zi	ip Code			10g. Citizen of	What Cour	ntry?
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Sab 9	To Be Co		(First, Middla, Last)		Jr.		NOR	18. Mother's Name (First, Middla, Maiden Surname) Anna Louise Watzic					
		19a. Informant's N	ame/Ralationship (t and Number or	Rural Route Num	ber, City or Town		Code)	
peimit. Peges 1 and 2 Department of Health e Important: if Nem 27 is any Injury or other tra			position ☐ Cremation 3 ☐ 5 ☐ Othar (Specif		to C	cemetery, cre	ostion (Name of Paith Cem. June 1, 1998 Baltimore, Md.						
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Attending Physical death. ector: After this by the funeral settles.	310	1 ⊠Natural 2 ☐ Accidant	5 Pending Investigation	28a. Date of In (Month, L	Jay Year)	Injury	М	28c. Inju Wo 1 □	ork?]Yes 2∐No		, , , , , , , , , , , , , , , , , , , ,		
To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A completely filled in by the funeral Director.	Certification:	3 ☐ Suicide 4 ☐ Homicida	6 Could not be determined	28e. Placa of I building,	Injury - At ho etc. (Spacif)	ome, farm, st	raet, factor	ry, offica		28f. Location City or T	(Straat and Num. own, State)	ber or Rure	al Route Number,
To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	Cartifying Ph	yaician: To the bes niner: On the basis and manner:	of examinal	wledge, deat tion and/or In	h occurrad vastigation	i at tha ti n, in my	ima, date and pla opinion, daath o	ice, and due to the courred at tha time	e cause(s) and m	anner as s and dua to	tated. o the causa(s)
within To the comp	ē (F	29b. Signature and	title of certifier	->			29	c. Licen	se nu <i>m</i> ber		29d. Date signe	ed (Month,	Day, Year)

State

RONALD J. STEIN 31. Date filed (Month, Day, Year) JUN 0 3 1998

30. Name and address of porson who complated causa of daath (Item 23a) (Type, Print)

2401 WEST BENEFERE AVENUE BALTIMORE MARYLAND

AS2402321 RS 9948

31, 1998

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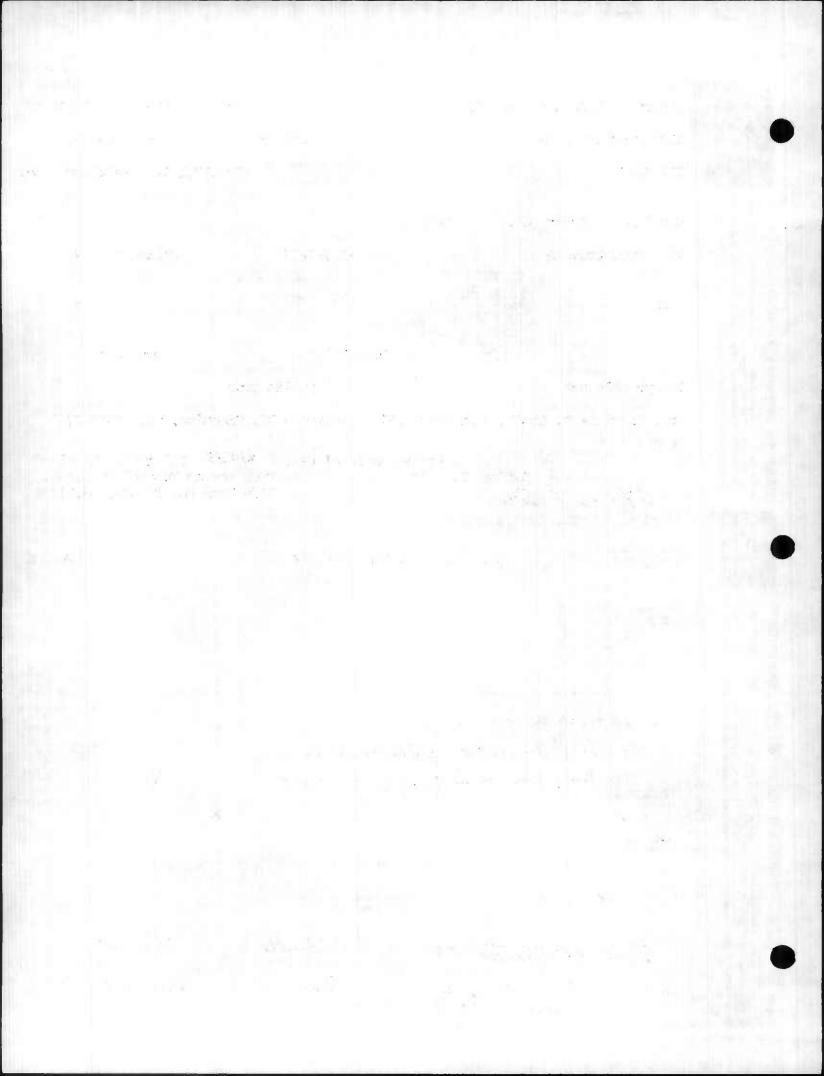
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 30, **Physician** Christine Antoinette Shealey 1998 10:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner 1305 Murgatroyd Road Fallston Harford Co. 5. Social Security Number If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Jan. 17, 1912 9. Birthplace (Stata or Foreign Country)
Baltimore, Md. 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 1□ M 2√ F Yrs. 212-03-6419 86 Director Usual Rasidence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Insida City Limits the Maryla 1 ☐ Yas 2 ➡ No Directo Maryland Harford Co. Fallston 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? an "natural", or Items 23a or Medical Examiner must be r 1305 Murgatroyd Road 21047-1835 United States Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 22050o If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. 1 and 2 should be filed within 72 hours after 1 □ Naver Married 2 □ Married 1 ☐ Yes 20 No Specify: Baltimore, Maryland 21215-0020 à 3℃Vidowed 4 Divorced White 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) (Give kind of work dona during most of working life. DO NOT use retired) Collega (1-4or 5+) Elamentary/Secondary (0-12) 100 08 Home Maker Own Home n/a 18. Mother's Nama (First, Middle, Malden Surname) 17. Father's Name (First, Middla, Last) and Mental Joseph Kolousek Emilie Drda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ħ Mrs. Patricia A. Lindley (Daughter) 2316 Wonderview Rd. Timonium, Md. 21093-3363 Health: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Res any injury or off 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 6/03/98 Bohemian National Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of FacilityRuck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee Jeffrey L. Gair 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disaasa, or complications that ceusad the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one causa on each line. **Physician** Immediate Cause (Final disease or condition rasulting in daath) /Medical 48 hours Cerebrovascular Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury Dua to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai that initiated evants resulting in death) Last Dua to (or as a consequence of) 89 USB signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown old cerebro vascular accident 24b. Wera autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? Completed -infant dementia bedbound state irector, page 2 s gastrostomy tube
25. Was casa rafarred to medical
axaminar? leg contractures 1 Yas 2 No 1 □ Vas 2 □ No Division of Vital I or Attending Physician: director. Be 26. Placa of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 1☐ Yes 2 No Certification: To this funeral 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Panding 1 Yas 2 No death. Investigation ofter death.

Director: A 2 ☐ Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours effer Funeral Dire letely filled in b Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Certifier Medicai within 24 ho To the Fune completely fi (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who complated cause of death (tem 23a) (Type, Print) 5505 Hopkins Bayview Circle Baltimore, Mb Bellantoni, mI 31. Date filed (Month, Day, Year) JUN 0 3 1998 Registrar

DHMH 16 Rev 6/95



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AND THE STORY CARD SHEET STORY STORY

Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 630 AM Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Mules If Undar 1 Year lu Himore If Under 24 Hrs. 6. Sax Birthplaca (State or Foreign Country) 7. Age (In yrs. lest birthday) Data of Birth (Month, Day, Year) Days Hours 00 M 20 F Yrs. 215-74-5078 35 10/24/62 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yos 2□No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CHESTER STREET 23 S. 21231 U.S. 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detas: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxicen, Puerto Rican, etc.) 1 X Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 -0-DRIVER TRUCKING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) JAMES SAMPLE HELEN HENRY 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) DWIGHT BROOKS (BROTHER) 3419 PARK LAWN AVE.-BALTIMORE, MD 21213 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) METRO CREMATORY 5/29/98 BALTIMORE, MD 21. Signeture of Funaral Service Licensee 22. Name end Address of Fecility ELIZABETH L. PHILLIPS 1721-27 N. MONROE ST.-BALTIMORE, MD 21217 aka 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Bety Onset and Death Immediate Cause (Final disaese or condition resulting in deeth) Doe to (or es a consequence of): eumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daeth) Last Due to (or es a consequence ot): Due to (or as e consequence of): Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2000 1 Yes 3 Probably 4 Unknown 24b. Wera autopsy tindings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case reterred to medical examiner? 28. Placa of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigetion 3 Suicide 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide The certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier 29b. Signetura and th 29c. Licanse number 29d, Data signed (Month, Dey, Year)

Division of Vital Records, P.O. Box 68760,

signed b peed page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, completely

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

Funeral

Director

r than "natural", or items 23a or the Medical Examiner must be r

Pages 1 and 2 should be filed within 72 sent of Health and Mental Hygiene.

f of Health

Department o important: If any injury or once. 8

Physician /Medical

Examiner

physician and the burial-transit

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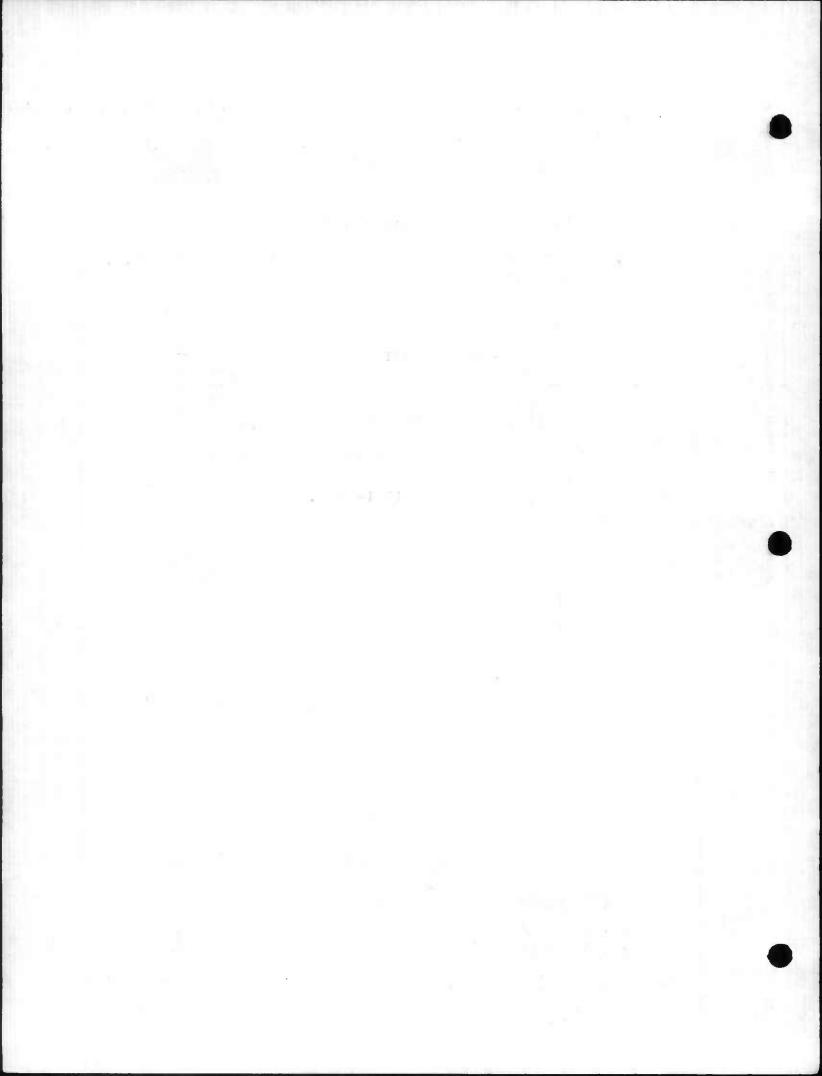
Certification:

Medical

Baltimore,

State Registrar

31. Dete tiled (Month, Dey, Year) JUN 0 3 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month MILDRED D. SHIRLEY May 30 1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Genesis Eldercare-Long Green Baltimore City N/A

Months

7. Age (In yrs. last birthday)

88

Yrs

1□M 2X F

If Under 1 Year | If Under 24 Hrs.

Hours

Days

8. Date of Birth

" ISAN

Birthplace (State or Foreign Country)

10d. insida City Limits

1 Yes 2 □ No

Sept. 18, 1909 Czechoslavakia

USA

Black, White, etc.

White

3 Probably 4D Unknown

24b. Wera autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

OLD COURT ROAD, BAHIMORE, MI

Physician /Medical Examiner **Funeral** Director item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Exeminar must be notified at with the Meryler 2 should be filed within 72 hours effer deeth v n and Mentel Hygiene. Is marked other than "natural", or itema 22s altimore, Maryland 21215-0020 permit. Peges 1 end 2 sh Department of Health and Important: If Item 27 ia m any injury or other traum 200.0. Physician

5. Social Security Number

212-44-9817

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore City Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 East Melrose Avenue 21212 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: þ 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) Own Residence Unk Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph n Dostal Anna Novakova 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1328 W. 41st Street, Baltimore, Maryland 21211

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore, Maryland 21211

20c. Location - City or Town, State Jeffrey W. Shaney (P.O.A.) 20a. Method of Disposition 1 Buriai 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Sono Woodlawn Cemetery 6/3/98 Woodlawn, Maryland 21. Signature of Fundinal Services 22. Name and Address of Facility Mitchell-Wiedefeld Home Martin D. Lawson
6500 York Road, Baltimore, Maryland
21212
23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Between Onset and Death herosclerotic /Medical Immediate Cause (Final DISEASE disease or condition resulting In death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by ti 1 Yes 2 No þ Completed 24a. Was an autopsy performed? hes page 2 2 No 1 Yes certificate or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1□ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural
2 Accident 5 Pending investigation efter death. 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 94 29d. Date signed (Month, Day, Year) $\mathcal{D}38708$ 29b. Signature and titla of certifier 0

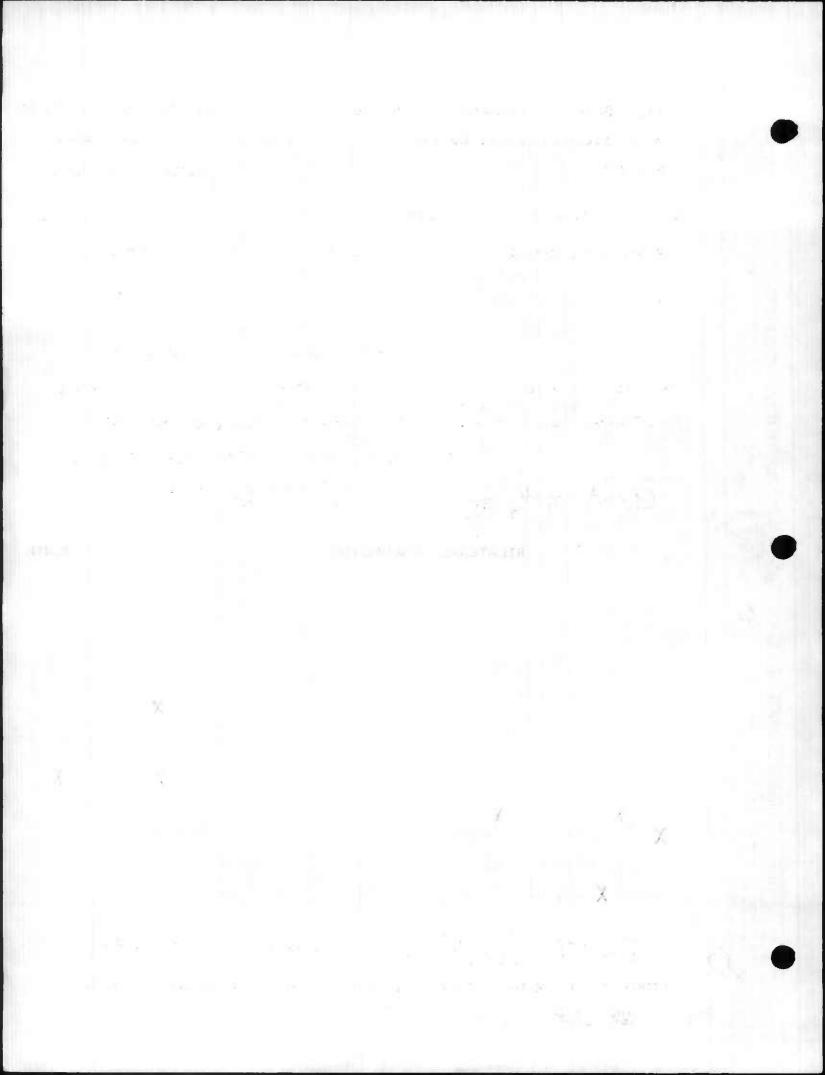
gistrer's Signature

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98

						C	en	iticate of	Deatn			Reg	J. No.		
			1. Decedent's Name (First, Midd	fle, Last)							2. Date			Maria	3. Time of Death
	Physici		ELIZABETH	FRAI	VICE.	e (ет	AHL.			Month	1AY	Day	Year	02:51 PM
	/Medic		4a Facility Name (If not institution			<u>.</u>	211		4b. City, To	wn, or L			4c. Count		OC. OI PI
	Examin	er	Saint Josep	-		Center				WSO					imore
1_								If Under 1 Year	If Under	-		of Dieb			
	Funeral	11	5. Social Security Number 213–36–9032	6. Sex 1 ☐ M 2 X F	7. Ag	e (In yrs. lest birthde 70 Yrs		Months Days	Hours	Min.	8. Date of (Month) May	h Dey	(eer)	Cour	lace (Stete or Foreign htry) Virginia
	Director					79 Yrs					May	14,1	1919	West	Virginia
	PC ,		Usual Residence of Decedent			10. 03 T		***							ad testas alle d'Issue
	nyteri how		10a. State 10b. Count			10c. City, Town or	LOCE	ation						1	0d. Inside City Limits
	M N	to	Maryland Balti	пюте		Towson									1 ☐ Yes 2X No
	128 E	Director	10e. Street and Number					10f. Zip Code				10	g. Citizen of	What Cour	ntry?
	A S		109 Kenilworth	Park Dr.				21204					U.	S.A.	
	eath sa	Funeral	11. Marital Status	12. Was Dec	cedent	Ever in U.S. 1	3 W	as Decedent of H	lispanic Ori	inin? (Sp	ecify Yes	or No-	14. Re	ce - Americ	an Indian.
	or d	5	1 Never Married 2 Ma	Armed F	orces?	No.	If '	as Decedent of H Yes, specify Cub	an, Mexicar	n, Puerto	Rican, etc	0.)		ack, White,	
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5		Completed by	(Specify only high	nt's Education est grede completed,)	(G	ive ki	nt's Usual Occup ind of work done	during mos	t of work	cing	"	6b. Kind of E	303111033/111	oustry
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nd	0 7 0 5	Be	17. Father's Name (First, Middle						18. Mothe	er's Nam	e (First, M	liddle, Mi	e <i>ide</i> n Su <i>m</i> e	me)	
/la		70	William Floyd						Blai	ne				(Osborne
an	AS DE E		19a, Informant's Name/Ralation	ship (Type, Print)	Daus	hter 19b. M	ailing	Addrass (Street	end Numb	er or Ru	rel Route N	vumber,	City or Town	n, State, Zip	Coda)
Σ			Mrs. Frances S	tahl Bern	ste		2 (Cayuga A	ve. B	ethe	esda.l	Marv	land 2	20817	
altimore,	f Health tem 27 i		20a. Method of Disposition			20b. Place of Di cemetery,				T	Date	-	0c. Location		own, State
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Bai	pemit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	Licensee	١.		22.	Name and Addre	ess of Facili	y efe1	d Hor	ne T	nc		
ш	20549		(Lolvert	m Yva	th	- 1	-	6500 Y					iic.		
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	Physician		23a. Part1. Enter the disease, or complications that author the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on the lie. Approximation of the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, interval B Onset and the mode of dying, such as cardiac or respiratory arrast, and the mode of dying, such as cardiac or respiratory arrast, and the mode of dying, such as cardiac or respirat												
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Division	or Attendation of Director:	ertification:	4 Homicide determination			ury - At home, farm, c. <i>(Specify)</i>	ગાવા	or, lactory, onice			City	or Town,	Stete)		
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	within 2 To the comple	Σ	29b. Signature and title of cartifi	9-1		MI		29c. Licans	se number			29	d. Date righ	ed (Mgnth,	Dey, Year)
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			30. Name and address of person	whomple	20 01	eath (Item 22a) (To	ne P	rint)					1	1	
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			31. Date filed (Month, Dey, Yeer	-		620 YOR	L.	ROAD	TOWS	JUN,	mer	RYLF	UPIT	212	04
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 2, MARGARET THOMAS 1998 11:20 AM CLINE /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner 309 Brightwood Club Dr. Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dale of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 M F Months Yrs. 027-36-4532 80 Jan. 19, 1918 Director Nevada Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Lutherville 10e. Sireel end Number 10f. Zip Code 10g. Citizen of Whet Country? 309 Brightwood Club Dr. 21093 USA Funeral death 12. Wes Deceden! Ever in U,S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Raca - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after of serment of Health and Mental hyglene. ortant: If Ifem 27 is merked other than "natural", or ite injury or other traumatic event, the Medical Emerical injury or other traumatic event, the Medical Emerical 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White ρ 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own home Home maker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Cline Nellie Μ. Gordon Lewis E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 309 Brightwood Club Dr. Lutherville, Md. 21093 Mr. Curtis R. Thomas/husband 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 6/3/98 Hilltop Service Corp. Towson, Md. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final diseese or condition resulting in death) PNEUMONIA DAYS Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Physiclan/Medi signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown RHEUMATIC HEART DISEASE Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed CONGESTIVE HEART DISEASE TYPE TWO DIABENES 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Death Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) P this 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. i or Attend aftar death Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide An 24 hou. Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the Within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and litle of cartifier D40008 aushale M.D. 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 9105 FRANKLIN SQUARE DR. BALTIMORE MD.

State Registrar

Dete filed (MoJUN') Year 1998

32. Registrar's Signature
Funda Davidson-Randalle

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day **Physician** 2, 1:50am 1998 Ε. June Doris Trager /Medical 4b. City, Town, or Location of Death 4c. County of Death 4s Facility Nama (If not institution, give street and number) Examiner N/A Baltimore 3735 Keswick Road If Undar 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2X) F 77 Yrs. Nov 29, 1920 Maryland **Director** 212-12-1686 Usual Residence of Decedent 1 and 2 should be filled within 72 hours after deeth with the Meryland Heelth and Mental Hygiene. In 27 is marked other than "natural", or frems 23s or 28s-f show r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Maryland Baltimore Yas 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code than "natural", or items 23s or the Medical Examiner must be 21211 U.S.A 3735 Keswick Road Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: þ 3\ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Maker Own Home 10 7 is marked other traumatic event, 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Jenkins Jessica Fisher 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 ment of Heelth ent: If item 27 is 3438 Hickory Ave., Baltimore, Maryland 21211 Anita Anderson (Daughter) other 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 8 Department of Important: If any injury or pace. 6/4/98 Druid Ridge Cemetery Baltimore, Maryland 21. Signatura of Funeral Sarvice Licensea 22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home allar 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that ceyled the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical **Examiner** Examiner that the death certificate be executed ettending physician and for use es the bunal-transi Sequantially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records. à 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 s Ser 1 Yes DINO 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hesidence 6 Other (Specify) 1 Yes 2 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how Injury occurred 28e. Date of Injury (Month, Day Year) 26b. Time of 28c. Injury at Work? Certification: After 1 Accident 5 Pending Invastigation efter deeth. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical completely (Check only one) within 2 To the !

9

29b. Signature and title of

ANLe

Registrar

31. Date filed (Month, Day,

and address of person who completed clause of death (Item 23a) (Type, Print)

32. Registrar's Signature Lulia Davidson

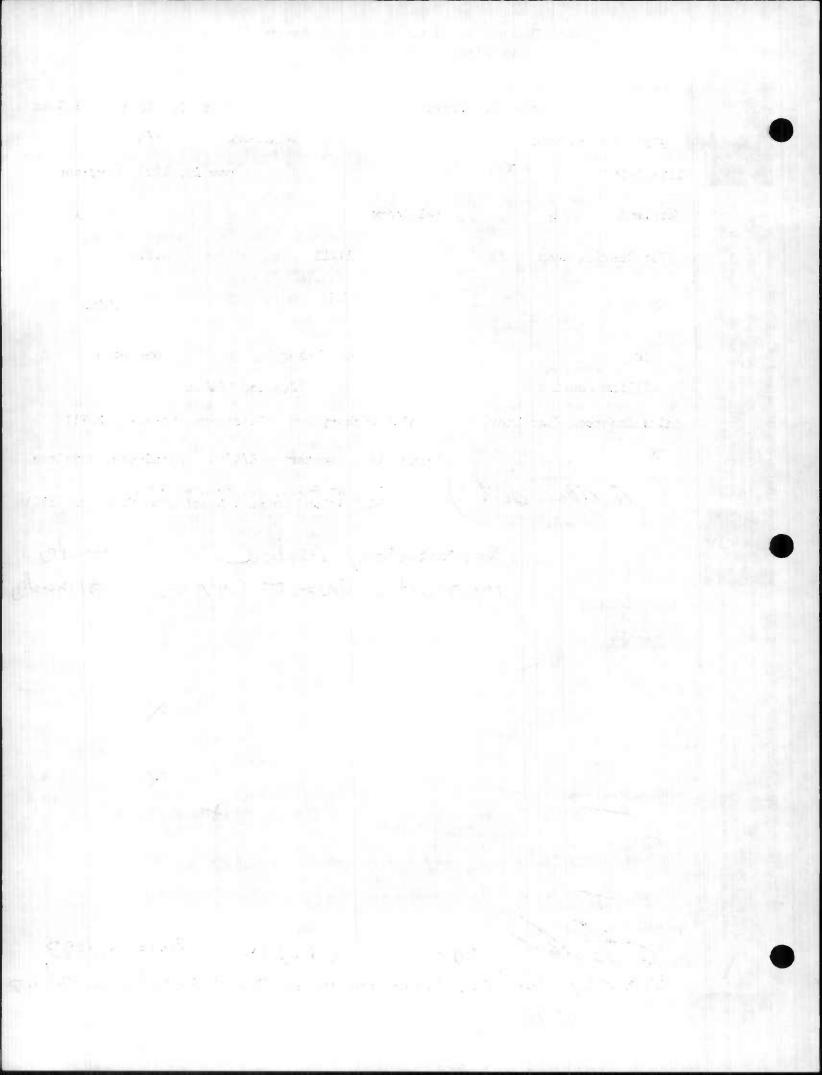
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29c. Licansa number

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29d. Data signed (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

								Cert	ificate	of i	Death			Reg. No.	9	0	1/246
	·		1. Decedent's Nama (First	, Middle, La	st)				7				2. Date of De	eath Day		Year	3. Time of Death
П	Physici Medi/		ERNA				TH	OMA	S				MA			998	12:30 AM
Ŷ.	Examir		4a Fecility Name (If not in							4	4b. City, To	wn, or Lo	cation of Deat		County of	f Death	
			Saint Jos	eph	Medica	al Ce	enter					0 W S O	n				more
	Funeral Director		5. Social Security Number 215-01-5770 Usual Residence of Deced		Sax I□M 2√F	7. Age (In	yrs. last birt	rhday) Yrs.	Months D	Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De July	23, 1	906	9. Birthple Count Sout	aca (Stata or Foreign hy) ch Carolina
	and and			County		100	c. City, Towr	or Loc	ation							10	Od. inside City Limits
	e Mary	Director	Maryland Baj	timor	e Count	у	Idel	wy1c	de								1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f show		10e. Street and Number 812 Reges	ster A	venue				10f. Zip Co		239			10g. Citiz	an of Wh SA	at Count	ny?
21215-0020	n 72 hours effer death with the Marylan "natural", or items 23a or 28a-f show ad cal Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2(3 ☒ Widowed 4 □ Di		12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	orces? 2X) No ve	in U,S.	If	as Deceden Yes, specify	Cuba	lispanic Orl an, Mexicar Specify:	n, Puarto	ecity Yas or No Rican, atc.)			- Amarica , White, e Whi	etc.
2-0	72 ho	ted		ecadent's E	ducation ade completed)		16a.	Decede	ent's Usual C	Occup	ation	t of worki	ina	16b. Kin	d of Bus	iness/ind	ustry
21	ithin it	Completed	Elementery/Secondery (College (1-4or 5+)		life. D	O NOT use	retired	d)	or works	19				
2	ges 1 end 2 should be filed within it of Health and Mentel Hygiene. If frem 27 is marked other than or other traumatic event, Ins.Me.	S		2 yr	S	Boo	okke	eper								Sales	
pu	d of H	Be	17. Fether's Neme (First, I	Aiddle, Last,)		18. Mother's Nam							, Meiden S	lumame		
Sign	should be and Mentel marked o	To	Rudolph Lou									eorgi					hompson
Maryland	12 st h and la m		19e. Informant's Name/Re														
	Health Health John 27 I		Judy Dobson 20a. Mathod of Disposition		ece)	2	Ob. Placa of				Road,	Balt	imore,			d 212 City or Tov	
jor	Peges nent of I nt: If its iry or of		1 XBurial 2 ☐ Crem	nation 3			cematar	y, cram	atory or othe	er plac	ce)	1					
tim	t. Pertant		4 Donation 5 DO			ruid						5/1/98	Pikes	svil	le, l	Maryland	
Baltimore,	permit. Peges 1 en Department of Heal Important: If Ikem 2 any Injury or other phose.		21. Signature Fungal Sarvica Anna 22. Nama and Addrass of Facility Mitchell—Wiedefeld Home														
	20240		Martin D. 18750. 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.											nd 2	1212		
п		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.										i	Approximate Interval Between Onset and Death				
я	Physician /Medicai																Onsot and Doug
1	Examiner		Immediata Cause (Final disease or condition resulting in death)		a. PNEL	IMON I	LH										
U		5	,			Due	to (or es e o	consequ	ienca of):								
	nsit /	Examiner			b												
-6	ficate be executed 3 physician and as the burial ansit	Exal	Sequentially list conditions if any, leading to immediat cause. Enter Underlying	s, te		Due	to (or as e o	consequ	ence of):							1	
68760,	certificate be ax nding physicial use as the buria	edical	Cause (Disease or Injury thet Initiated events	~	C	Dua	to for an a c	oneagu	ance of):							-	
68	flicat g phy as th	B	resulting In death) Last Dua to (or as a consequence of):														
Box	leeth certific attending pl	3			d											-	
ä	deeth e atten ed for u	Cla	Part II. Other significant c	onditions o	ontributing to d	eath but no	y reculting in	the unr	dadvina cau	se niv	ren in Part	f	23h Did	tobacco s	iss conf	ribute to	the cause of death?
0	as thet the deeth or igned by the attend be deteched for us	Physician/							ourrying out	30 g.v	or are	••		Yes 2		3 Prob	
D.	the det	by P	CHRONIC	ATR.	LAL FI	RKTT.	LATIC	N									
of Vital Records,	requir een s hould	Completed t	À									·	24a. Was perf	an autops ormed?	iy	ava	ore autopsy findings allable prior to appletion of causa death?
ď		E											10	Yes 2	No	1□	Yes 2□ No
ita	iclan: The	Be	25. Was case referred to r	medical							26. Place	e of Death	(Check only	one)			
>	Physician: this certific	To	examiner? 1 ☐ Yes 2 🔀 No		Hospitel:	Inpatient	2 ER/Ou	tpatient	3□ DOA	Oth	ier: 4 🗆 Ni	ursing Ho	ma 5□Res	Idenca 6	Othe	r (Specify)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page			Pending Investigation	,	of Injury th, Day Ye		ime of njury	M 28c	Injur Wor	yat k? Yes 2 □		28d. Describe	how Injury	occurre	id	
Division	or Attending after death. Diractor: After in by the fune	Certification:	3 ☐ Sulcide 6 ☐	Could not b determined	e 28e. Piece	of Injury -	At home, fe	rm, stre	et, factory, o	office				(Street and wn, State)	Numbe	r or Rura	l Routa Number,
Ω	pital o	Ce	20a Cartiflar	artifulne Dh	welsten. To the	hast of mu	, knowledge	dooth	accurred at t	the tir	no date as	nd place	and due to the	causa(s)	and mar	nor ee et	etad
	To the Hospital within 24 hours: To the Funeral completely filled	29a. Certifler (Check only one) 29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause of examination and/or invastigation, in my opinion, death occurred at tha time, date and manner stated.								date and	place, ar	nd due to	the cause(s)				
	withi To the	Σ	29b. Signature and titla of	cartifie	/		_		29c. L	icens	e number				7 -	(Month I	Dey, Year)
	6			—	200	5	w	7	D37	725	54			7	12	8	98
	11	ŀ	30. Name and address of p	person who	completed caus	e of death	(Item 23e) (Type, P	rint)								
	V		BOON P. LI	IM, M						TOV	VSON,	MAR	YLAND	212	04		
	Sta Registi	_	31. Date filed (Month, Day		32	egistrar's	Signature	Pande	202								

Please Type or Print in Biack Indelibie ink. Assure All Copies Are Legible.

Certificate of Death	Reg. No.	1164	
		1724	
e of Maryland / Department of Health and Men	tal Hygiene	1701	0

Physician
* /Medical
Examiner

Ann Dixon M.D.

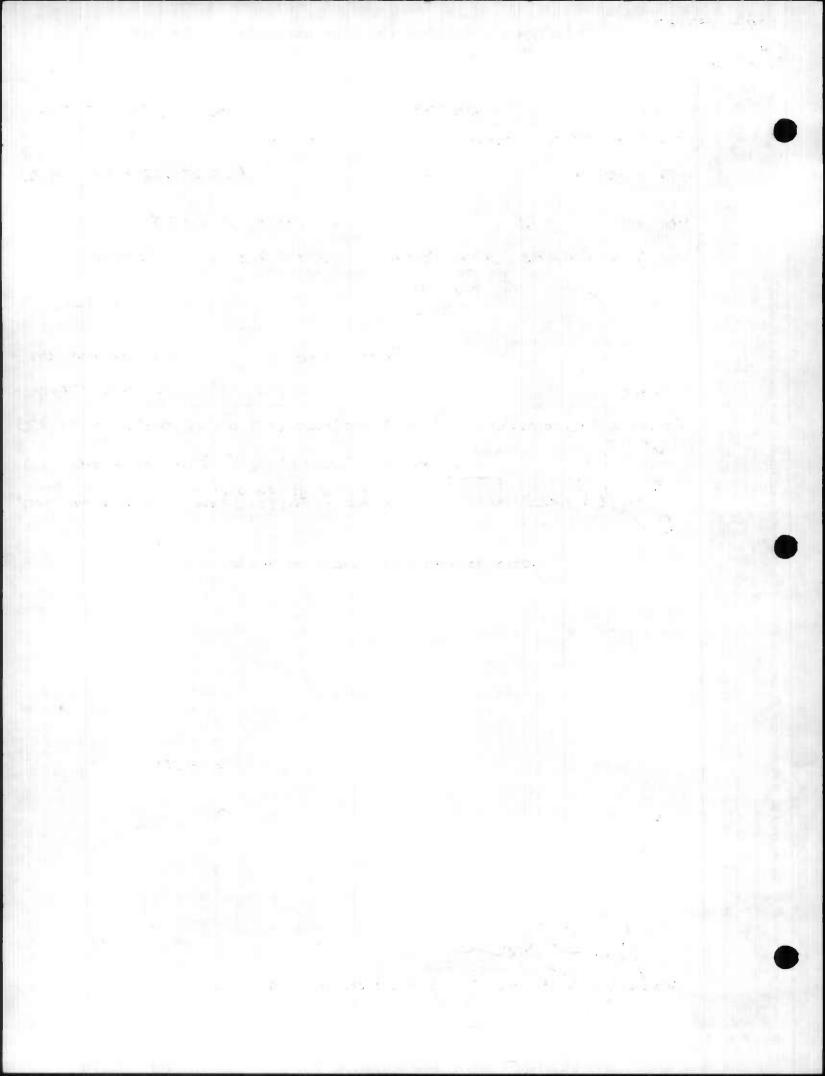
31. Date filed (Month Day, Year)

98-	-3078-510)		Otate of Ivia	yıaı		cate of			Reg. No.	17	247			
			1. Decedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death			
	Physician * /Medical		BERNARD	WA	SHI	NGTON			Month MAY	31, 19	Year 998	2015 PM			
	Examine		4e Facility Neme (If not institution, giv						Location of Deat	4c. County					
			502 NORTH CARROLI			4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	Inder 1 Year	BALTIMO			/A	10.			
	Funeral		5. Sociel Security Number 6. S 219-28-5594	ex M 2□ F 7. Age	(In yrs.		nths Deys		. A(Month, De	y, Year)	Country	ce (Stete or Foreign			
ш	Director	-	Usuel Residence of Decedent		V	0			Aug.	0,1132	PITT	ZYLAND			
	how how		10a. State 10b. County		10c. Cit	y, Town or Location	-				10d	. Inside City Limits			
	death with the Maryland ms 23a or 28a-f show mat be notified at	5	MARYLAND M	VA			BA	LTIMO	PRE	ZITY		1 ☑ Yes 2 ☐ No			
	ifter death with the Ma r Items 23a or 28a-f s inter mast be notified	5	10e. Street and Number		1	^				10g. Citizen of V	What Country	7			
	ath w	8		ROLLTO		AVENUE		2123		14 500	USA.				
w		5	11. Merital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E		If Yes,	specify Cub	an, Mexican, Pue	Origin? (Specify Yes or No- ican, Puerto Rican, etc.)						
020	0 0 0		3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 No If Yes, Give Year or Detes:	2-15	603 10Y	es 21 No	Specify:		Specify	BLA	ACK			
5-0020	2 4 4 4	3	15. Decadent's Ed	ducation	2-10	16a Decedent's	Usual Occup	pation	a dela a		16b. Kind of Business/Industry				
2121	be filed within 72 ho ttal Hygiene. d other than "nature event, the Med call Re Commissed	2	(Specify only highest gre Elementery/Secondary (0-12)	College (1-4or 5+	·)	life. DO N	OT use retire	during most of w	orking						
	ygien fr. th	5	UNKNOWN			TRU	ICKI			SELF-EMPLOYED					
and	tal H d out	2	17. Father's Name (First, Middle, Last)						ame (First, Middle			1- 1			
Z	should be nd Mental marked o	2	UNKNOWN 19a. tntormant's Name/Relationship (Tong (Print)		40h Mailles Ad	dans Chan	JEAN	ber or Rurel Route Number, City or Town, State, Zip Code)						
Maryland	d 2 sh th end 7 is m trsum					1									
	ges 1 end 2 should t of Health end Mer if Item 27 is marks or other traumatic	VERNICE WILLIAMS (ARETAKER) GOQ N. CARROLLTON AVE. BALTO, 20a. Method of Disposition 20b. Placa of Disposition (Neme of Dete 20c. Location - City													
TO	ages ent of it: If It y or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Completery, crematory or other place)												
Baltimore,	permit. Pa Departmen Important: eny Injury once.	-	21. Signature of Funeral Service Licer		0.			ess of Fecility	0 0 10	-2 Ti	75 77	145, 170,			
ä	permit. Departiment. Import. eny inj		11/500	man		Jo.	SEPS	+ H. R	ROWN	JK, FU	NERA	L HOME MD. 21217			
	ALC: N	1	23a Part Enter the disease, or com	plications that caused i	the deat	h. Do not enter the	mode ot dyi	ng, such as cardi	ac or respiratory a	rrest,	i A	pproximate			
-	Physician		and tailure. List only	one cause on each line								Inset and Deeth			
7	/Medical Examiner	1	Immediate Ceuse (Final disease or condition	a Arterioso	alor	ntic Car	liouse	oular Di	coaco						
п	A STATE OF THE PARTY OF THE PAR		resulting in death)			or as a consequenc		cuidi bi	sease						
	nsit			b											
-	al-trar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as e consequence of):													
68760	8 50 6		Cause. Enter Underlying Ceuse (Diseese or injury that initiated events	c	ue to /c	r as e consequence	e of):				-				
_	5 5 6	3	resulting in death) Last		00 10 (0	as e consequence	5 017.								
Box	es that the death certification of the attending be detached for use a by Physician MA.			d	_										
	o death	2	Part It. Other significant conditions of	ontributing to death but	t not res	ulting in the underly	/ing cause gi	ven in Part I.	23b. Dld	tobacco usa co	ntribute to ti	he cause of death?			
P.0	ed by the detached								1 🗆	Yes 2□ No	3 Probe	bly 400 Onknown			
	8 58 5	2									D4h Word	autoney tindings			
Records,	The law requires rate has been sign page 2 should be								24a. Was	an autopsy ormed?	comp	autopsy tindings able prior to pletion of cause			
360	The law ate has the page 2 s									ECTION	of de	eth?			
<u>a</u>	certificate h	-							1	Yes 2 No	10'	Yes 2 No			
Vital	sician:	3	25. Was case reterred to medical examiner? 15. Was case reterred to medical	Hospital:		SD(O)	J DOA Ot	hor-	eath (Check only		(C/5-)				
of	2 24 F	•	27. Manner of Death	1 ☐ tnpatien	/	ER/Outpatient 3	DOA DOA DO	4 LI NUISING	Home XXRes 28d. Describe	how injury occur					
Division	after death. Director: After in by the fune		1 DNaturai 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Dey	Year)	Injury N		ork?]Yes 2∐No							
N/S	Attend ir death ector: by the	3 Suicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 28e. Placa of Injury - At home, tarm, street building, etc. (Specify)					actory, office			(Street end Numb	per or Rurel I	Route Number,			
ā	plat or Attending Pours after death. eral Director: After I filled in by the funeral	3	4 Homicide		July or 10										
	n 24 hours in 24 hours in 24 hours in the Funantal pletsly filled adjoal Ca		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of niner: On the basis of	my kno	wiedge, deeth occu	ation, in my	ime, date and place	ca, and due to the	cause(s) and ma	anner es stat	ed. ne cause(s)			
	adit adi		Only 7.51	and manner stat	ed.										
	of a to		29b. Signature and title of certifier	2.2			29c. Licen	411		MAY 31		oy, rear)			
	axl	-	1/2	M	=										

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rav 6/95

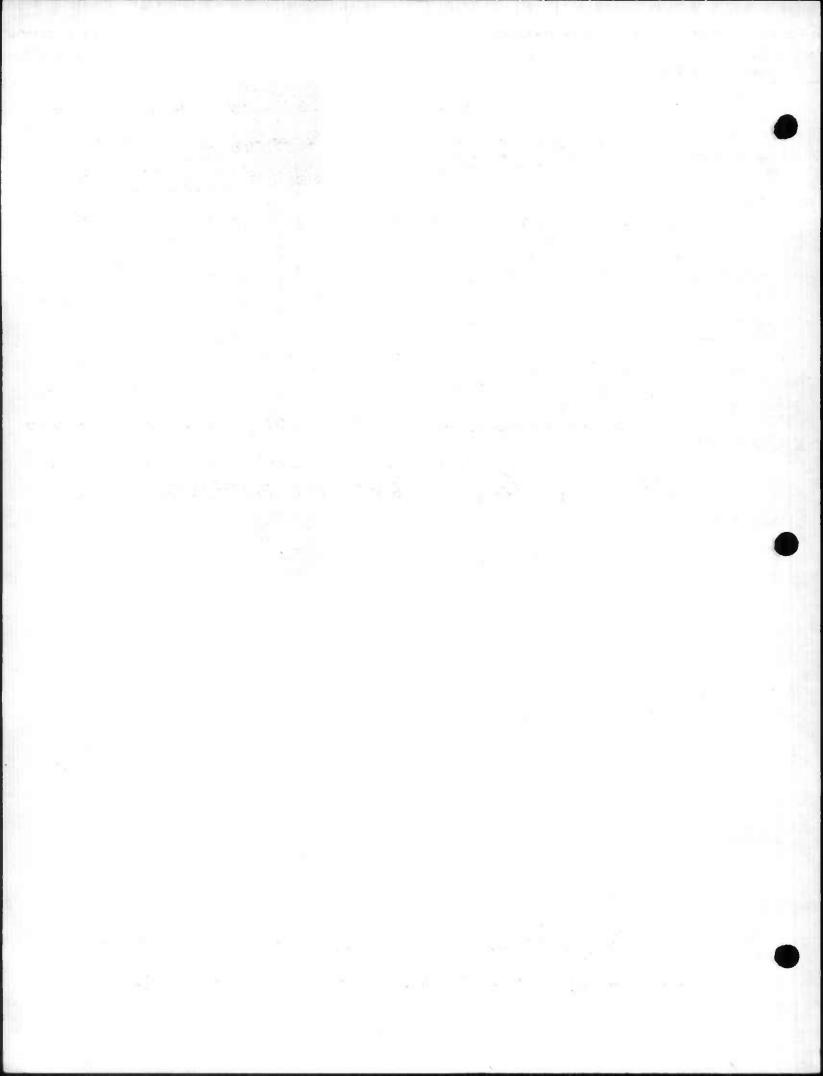
State Registrar



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State of Maryland / Department of Health and Mental Hygiene

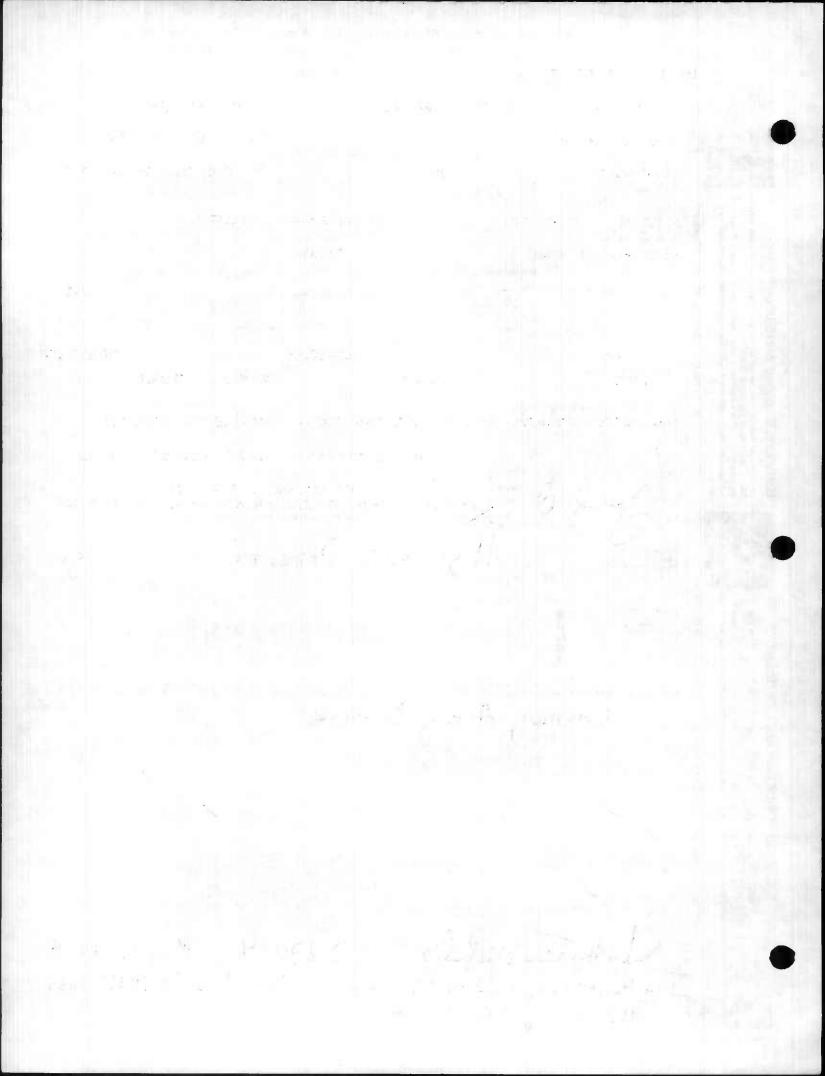
				otato of Maryland	Certificate o			eg. No.	98	17248
	Physici	an.	1. Decedent's Name (First, Middla, La.	91)			2. Dete of Dear Month	h Day	Year	3. Time of Death
	/Medic		VINIE 0.	WHIT	E		MAY	29, 19		11:30 PM
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or I		4c. County	of Death	
		Н	5. Social Security Number 6. S	OR COURT	1 22 22 2 2 2 2 2		THORE		0 000	9
	Funeral Director			ax 7. Age (In yrs. le	Yrs. Months Day		8. Date of Birth (Month, Day SEPT, o	Year) 1923	9. Birthple Counti	Ce (Stata or Foraign
	Mend Mend		10a. State 10b. County	10c. City	, Town or Location				10	d. Inside City Limits
	Men	tor	MARYLAND N	A	3	ALTIHO	ORE C	171/		1 PYes 2 □ No
	or 28	Director	10a. Street end Number		10f. Zlp Code)	1	0g. Cityzen of V	Vhet Counti	y?
	23a		2435 ANN.	OR COUR	27	212	30	6	ISA	
	terne	Funeral	11. Marital Status	12. Was Decedant Ever in U,S Armed Forces?	 13. Was Decedant of If Yas, specify Control 	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - America k, Whita, e	
20	filed within 72 hours efter deeth with the Meryland Hygiene. ther than "natural", or items 23a or 28s-1 show thit, the Medical Examiner must be notified at	by F	1 ☐ Never Marriad 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas:	1 □ Yes 2 ₺N	o Specify:		Specify	BL	ACK
21215-0020	n 72 hours "natural",		15. Decedent's Ed	ducation	18a. Decedent's Usuel Occ	cupation	100	16b. Kind of Bu		
218	within 7 ene. than "n	Completed	(Specify only highest gre Elementery/Secondary (0-12)	College (1-4or 5+)	(Giva kind of work dor life. DO NOT use reti	ired)				
	a filed with If Hygiene. other than		10TH GRADE		Home	MAKEN		OWN		ME
Maryland	P P P	Be	17. Father's Name (First, Middle, Last)	~		1	ne (First, Middle, I		-	
Z	should be und Menta marked umetic ev	2	GEORGE 19a. Informent's Name/Relationship (ORI	19b. Malling Address (Stre	DEL				HTFUL
Ma			DEBORAH GE							21230
re,	F F F		20a. Method of Disposition	20b. Pla	aca of Disposition (Neme of metery, cremetory or other p		Dete	20c. Location -	City or Tow	m, State
mo	Peges net of nrt: If its iry or o		1 Burlel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Hamoval from Stata		METERY L	6-4-98	ANSA	alu al	E M.D.
Baltimore,	nit. antmoorts inju		21. Signature of Funeral Service Licen	500	22 Name and Add	trace of Facility/				
Ω	pen fmp any		(6). (On)	2140 N. F	BROWN JR	NUE, BAL	TIMORE,	MD.	21217
			23e. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused the death.						Approximate nterval Between
	Physician			٥ ١		0 1			-	Onset and Death
7	/Medicai Examiner		Immedlete Cause (Fine) disease or condition resulting in death)	e. Cardiojul Duelto (or	monary -	a: me			. !	2 mo.
		er)			t t	
	outed Id ansit	Examiner	Sequentially list conditions	U. Total	as a consequence of):				1) mo
0,	tificate be executed g physician and es the bunal-transit		Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that in the condition of the conditions of the c							
68760,	ate b thysic the b	edical	that initieted events resulting in deeth) Lest	Dua to (or	es a consequanca of):				1	
	5 00		L L	d						
Box	the deeth cert y the attending sched for use	cian								
0	the d	Physician/M	Part II. Other significant conditions of	-		given in Part I.		/ _		the causa of death?
٥,	s that	by P	hypothesim	, MI, CHI	r, y/v			es 20 NO	3 1100	ibiy 4 Olikilowii
Vital Records,	requires that been signed b should be dete			,	,		24a. Was a	n autopsy	eva	e autopsy findings lable prior to
ecc	¥ 50 €	Completed		_			, , , , , , , , , , , , , , , , , , , ,	_	of d	pletion of causa path? N/A
E B	The ate h	Con					1 □ Y	s 2DNo	1 🗆	Yes 2□ No
Vita	Physician: The this certificate rai director, pag	Be	25. Wes case referred to medical examiner?	Hospital:		26. Plece of Dec	eth (Check only or	(e)		
of	Phys this rai di	. To	1 Yas 2 No 27. Manner of Deeth	1 □ Inpatient 2 □ E	ER/Outpatient 3 DOA 28b. Time of 28c. In	4 LI Nursing F	ome 5 Reside			
on	Attending Is death.	tlon	1 Neture 5 ☐ Pending investigation	(Month, Day Year)	Injury V	Vork? □ Yes 2 □ No	200. 20001100 11	overnous account		
Division	Attendi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	288. Placa of Injury - At nor	me, farm, street, factory, offic	:a	28f. Location (Si City or Town		er or Rurel	Routa Number,
Ö	rs efter al Dir	Cert	4 Litolinade	building, etc. (Specify)			City of Town	1, 31616)		
	To the Hospital or Attend within 24 hours effer death To the Funeral Director:, completely filled in by the	edical	(Check only 2 Medical Exem	ysician: To the best of my know liner: On the basis of exemination	riedge, death occurred at the on and/or investigation, in my	time, date end place	, end due to the c	ause(s) and me ate and placa, e	nner as sta	ted. he ceuse(s)
	the thin 2 the mplet	Med	one)	and menner stated.		nse number				
	D N O		29b. Signature end titla of certific	7-		409 F9	2	9d. Date signed	3/af	Dy, 1881)
	4/		30. Name and eddress of person who	Tomo blad on the district the				9	/7V	
	8		TACK HON GMD	3001 S.	Hanova 5-	t Ba	It Mo	1 21	225	>
	Sta	te	31. Date filed (Month Day, Year)	32. Regist ary Slor	bro , to					



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

]	Item	10c Per FH Film				tificate of		d Mental Hy	Reg. No.	98	1724
Physician /Medical		ecedent's Name (First, Mid	BERNAI		WETZEL		41 Ch T	2. Date of De Month MAY 30), 1998	Year	3. Time of Death 1:15pm
Examiner	10.0	acility Neme (If not institution) CHARLTON		mber)				or Location of Deat VDALLSTOWN		of Deeth	Œ
Funeral Director		ocial Security Number 19–18–9613	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 72		If Under 1 Year Months Days	Hours N	Hrs. 8. Date of Bir (Month, Di DEC.	th 30,1925	9. Birthpl Count MARY	lace (State or Foreig try) 'LAND
. A.		State 10b. Count	ty	10c. Cit	y, Town or Lo	cation				11	0d. inside City Limit
ta or 28a-f show	MA	ARYLAND BA	LTIMORE		-	RNADALLS	TOWN-	RANDALLSTOW	N		1□Yes 2□N
or 28a-f s	10e.	Street and Number	DOAD			10f. Zip Code	22		10g. Citizen of V		try?
2 2 2	5 11 A	Marital Status	12. Was Dec	cedent Ever in U	S. 13. V	211		? (Specify Yes or No	US. 0- 14. Rac	A e - America	an Indian,
,	3	□ Never Married 2 Ma □ Widowed 4 □ Divorce	Armed Fi arried 1 ☐ 4 es If Yes G	orces? 2 DNo ive	1	Yes, specify Cub	en, Mexican, P	uerto Rican, etc.)			
natural'		15. Decede (Specify only high	ent's Education lest grade completed))	16a. Decad	lent's Usual Occup kind of work done OO NOT use retire	ation during most of	working	16b. Kind of B	usiness/inc	Justry
9 6	Eid	ementary/Secondary (0-12)	College ((1-4or 5+)	life. L	TECHNI			EVISION		
I to a	17. F	Father's Name (First, Middle OTTC	a, Last)	WF	ETZEL	TECHNI	18. Mother's	Name (First, Middle	n, Malden Surnam UNKNOW	ne)	LVIDION
	2		antin (Tuna Caint)			a Address (Cares		r Rural Route Numb			Code
5 ~ 3		Informant's Name/Relation RS. BETTY JAN		(WIFE)				ANDALLSTO			Code)
nent of Health nt: if Item 27 iry or other tr	1	Method of Disposition	0 DD		Piece of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location -		
ant: if		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		51010	BALTI	MORE HEB	REW	6-2-98 RI	EISTERST	OWN,	MD
Department of Her Important: If Item any Injury or othe phos.	21. 5	Signature of Funerel Service	a Licensee	P	22	. Name and Addre		N & BROS.	INC.		
	934	Toll	D C	rives		900 REIS	TERSTO	VN ROAD BA	ALTIMORE	, MD	21208 Approximate
hysician	2.50	Part. Enter the disease, show, or heart failure. Li	st only one cause of	tech line.	n. Do not ent	ar the mode of dys	ig, such as can	GIOC OF TOOPHUTORY	M1001,	1	interval Between Onset and Death
Medical	Imm	ediate Cause (Final ase or condition	F	112h	0 m 0	15 0	emen	tic		1	340015
caminer	resu	ilting In death)	a	Due to (c	or es e conseq			1.9		i	200
in end istransit Examiner			b							1	
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certificate has rector, page 2								1 🗆	Yes 2000	10	Yes 2□ No
s certific director,	25. \	Was case referred to medic examiner? I □ Yes 2 ☐ No	Hospitei:	la constitue de la constitue de la constitue de la constitue de la constitue de la constitue de la constitue d	I EDIO	Oti Doc Oti	ner:	Death (Check only			
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within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	29a.		ring Physician: To the al Examiner: On the b and mar								
within To th comp		Signatule and title of certif	A	ΛΛ		29c. Licen	se number		29d. Date signe	ed (Month,	Day, Year)
		Mr. Hai	le gr	Jel JA	Y	D.	2703	34	May 2	31	1998
	30.1	Name and address of person	n who completed cal	se of death (item	n 23a) (Type,	Print)	10.	000	11.13.	111	0.123
	31 5	Sq Hunter Date filed (Month, Day, Yea	Copela	H MI)	5310	019(0)	1+ Kac	d Kand	allstaul	MO	21135
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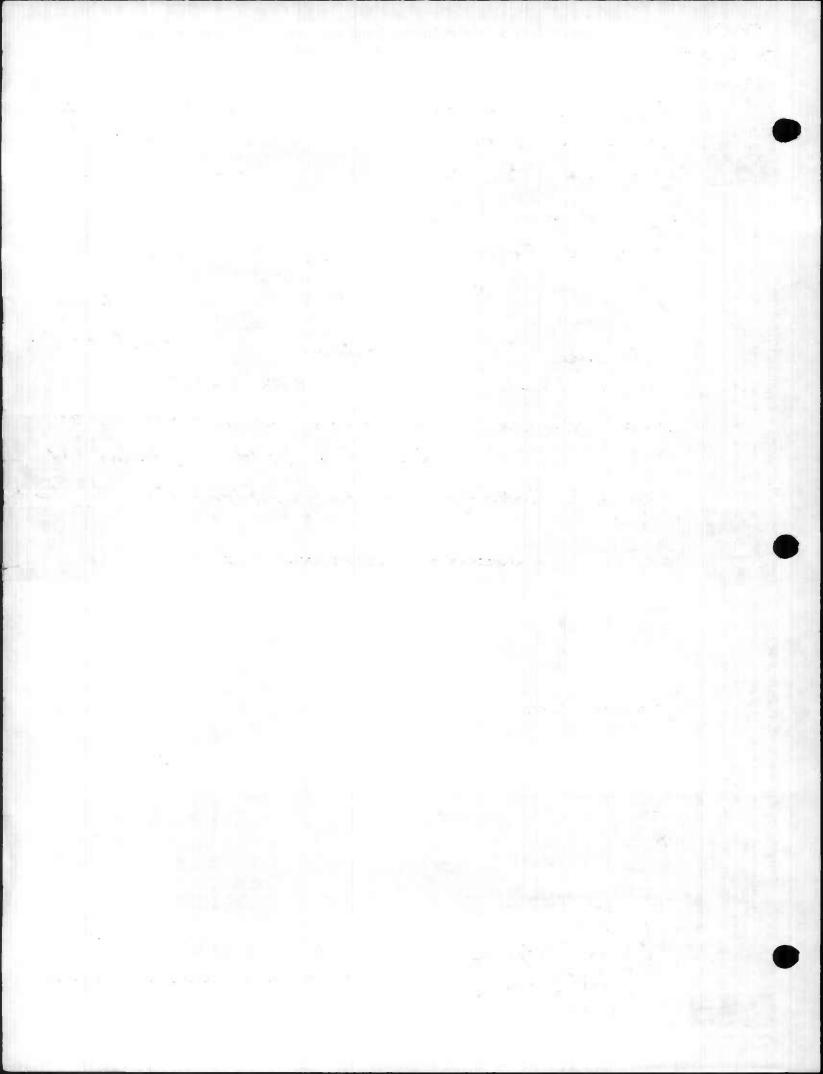


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UVA	AATTAININGT

EV		EY Stat		irtment of Health and I tificate of Death		98 1	7250							
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1	/Medical Examiner	4e Facility Neme (If not Institution, give street an		4b. City, Town, or I		tc. County of Death	2.25 A							
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	anyla ahov		10c. City, Town or Lo			1	0d. Inside City Limits 12 Yes 2 □ No							
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	led within 72 hours after death with the Maryland ygjens. Ner than "natural", or items 23s or 28s-f show it, the Medical Examination collified at Completed by Funeral Director	5922 BENTON	•	7120		14. Rece - Americ	on Indian							
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ore	it of H if iter or oth	20e. Method of Disposition 12 Buriel 2 Cremetion 3 Removel 6	rom State	sition (Name of patory or other place)	Dete 20c.	Location - City or To	wn, State							
Ë	a F + ×	4 ☐ Donetion 5 ☐ Other (Specify)	arbords	so men IK	91	muno	1829							
Baltimore,	Departmen Departmen important: any injury once.	21. Signeture of Funerel Servica Licensee 22. Name end Address of Fecility												
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я	Physician	I was to see the see					Onset and Death							
8	/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) e. An	teriosclerotic (Cardiovascular Di	sease									
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	deat de att ed for	Pert II. Other significant conditions contributing	to death but not resulting in the ur	derlying cause given in Pert I.	23b. Did tobac	co use contributa te	the cause of death?							
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Division	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	determined 200. F	Piece of Injury - At home, ferm, stre puilding, etc. <i>(Specify)</i>	et, factory, office	City or Town, St		ii i i i i i i i i i i i i i i i i i i							
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Physician: To	o the hest of my knowledge, death	occurred et the time, date end plece	and due to the cause	(s) and manner as s	toted							
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	vithin on the complete on the	29b. Signature and tiled of certifler		29c. License number	29d. I	Date signed (Month,								
	->-0	I M		O.C.M.E	MA	Y 30,199	8							
		30. Name and address of person who completed	cause of death (Item 23e) (Type, I	Print)										
		(AMD XON		111 Penn Street,	Baltimore,	Maryland	21201							
	State	31. Date filed (Month, Dey, Year) (32. Resident Storature Sundson-Re	nd 00										
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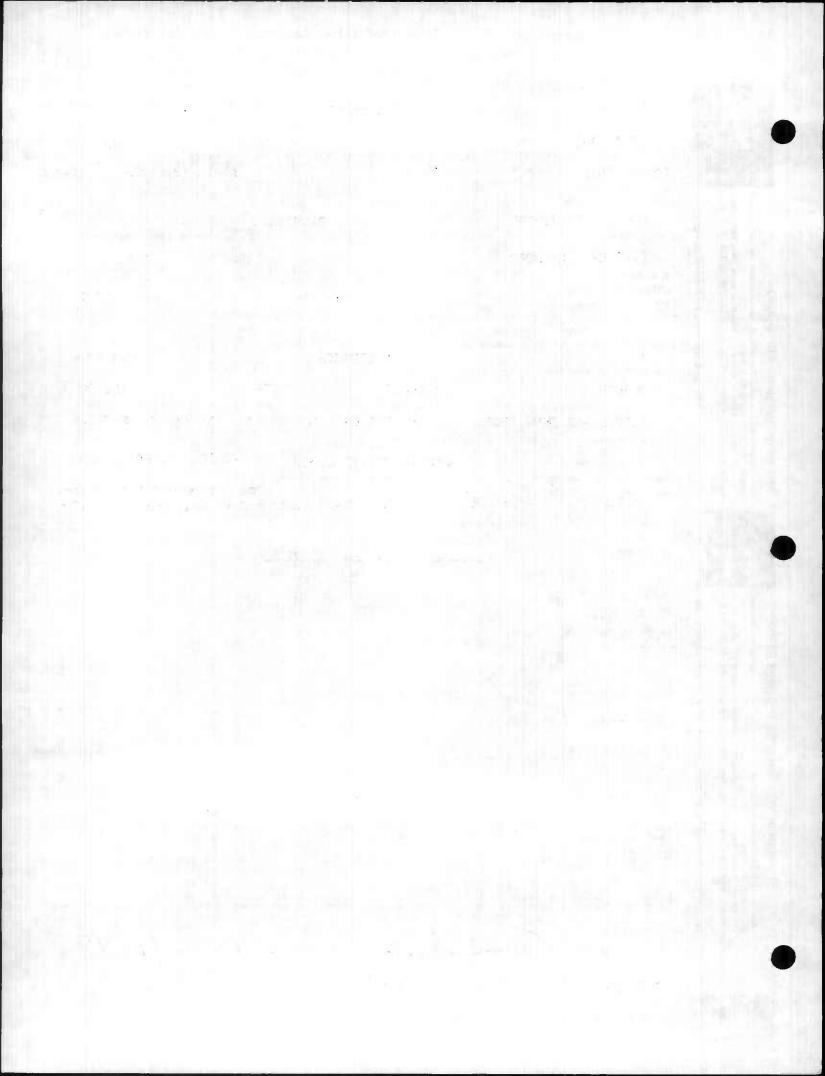
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** JUNE 1, 1998 FLORENCE 9:00 AM WARTZMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner 8241 BRATTLE ROAD BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year)
APRIL 19, 1923 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1□M 200 F 75 Yrs. 220-76-8513 POLAND Director Usual Residence of Decedent the Manyland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 눕 r than "naturel", or items 23s or 8241 BRATTLE ROAD U.S.A.

14. Race - American Indian,
Btack, Whita, atc. 21208 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 1 Yes No If Yes, Give Yaar or Dates: 1 Never Merried 2 Married 1 Yes 2 XNo Specify: Specify: WHITE þ ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE OWN HOME 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be JOSEPH CZARNOPOL RIVKA (UNKNOWN) 2 19a. tnformant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH WARTZMAN (SON) 201 OLD CROSSING DRIVE BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 6/2/98 ROSEDALE, MD RADOMER VEREIN CONG. 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Baltimore, MD 21208
Approximate the mode of duting such as cardiac or raspiratory arrest.

Approximate 23a. Part1. Entar tha disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. tntervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical den Examiner Due to (or as e consequence of): Examiner physician and s the burial-transit the death certificata be executed Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of) 80 attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Onknown 1 Yes 2 No that Records, Š The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata hes b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: T s after death. I Director: After this certificat ed in by the funeral director, pi 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 AesIdence 1 Yes 2 No 6 ☐Other (Specify) 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident n 24 hours after dea ne Funeral Director niataly filled in by th 6 Coutd not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as stated. Medicai To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 12830 Y WD 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Marin St 750 tephan Sieg mo 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Davidson-Randall JUN 0 3 1998 Registrar

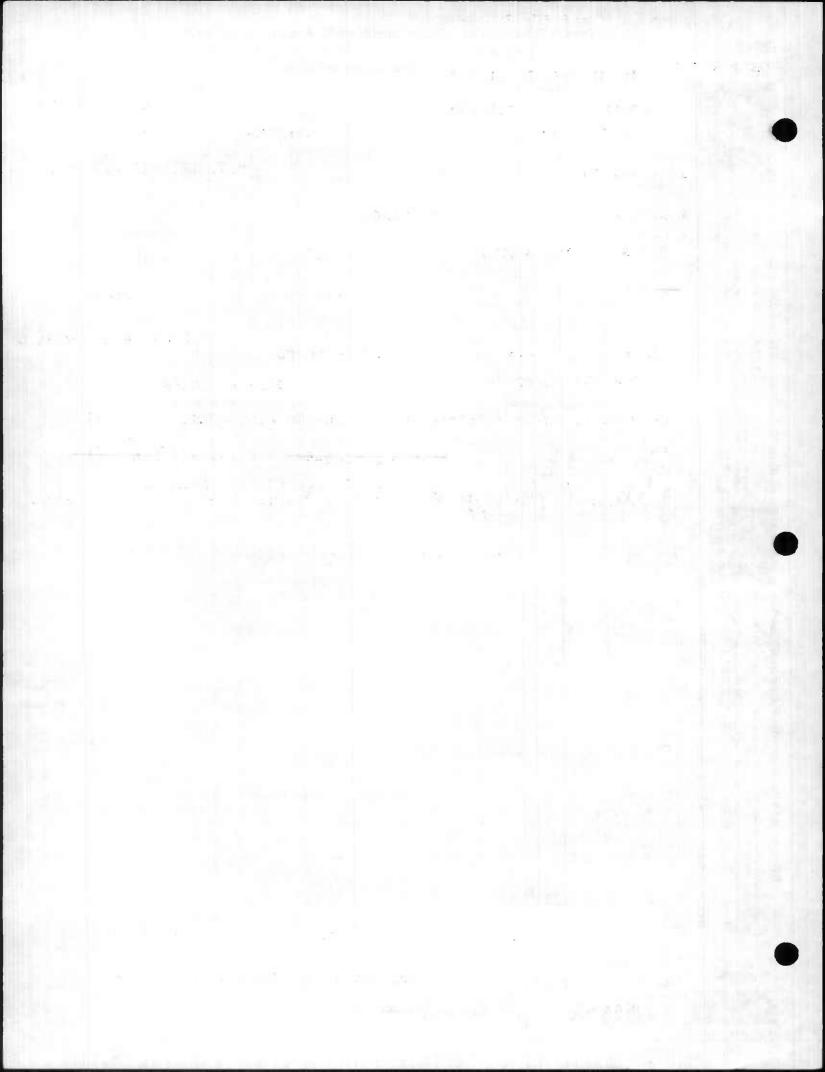
DHMH 16 Rev 6/95



State

Registrar

JUN 0 3 1998



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 253 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death HERI Month NESTBROOK 5:29AM 28 1998 MA 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death N/A BALTIMORE GOOD SAMARITION HOSPITAL If Under 1 Year | If Under 24 Hrs. S. Date of Birth (Month, Day, Year) SEPT 11,1948 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Deys Months Hours 1 □ M 2 🖫 F LINCOLNTON, N. C. 49 Yrs. 219-52-7461 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MARYLAND BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 5802 WAYCROSS ROAD. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: AFRO. AMERICAN 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) BALTIMORE CITY SCHOOL COUNSELOR 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) RACHEL WESTBROOK REV. LUTHER J. WESTBROOK, SR. С. 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 MONTPELER STREET, BALTIMORE, MARYLAND 21218 REV. LUTHER J. WESTBROOK, JR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE CEMETERY 6/2/98 BALTIMORE, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME, P. A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21217 Approximate Intervel Between Onset and Daath SEPSIS Immediate Cause (Final disease or condition resulting in deeth) INFARCTION Sequentially list conditions, if eny, laeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1'S Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Dale of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury et Work? 1-Divatural 5 Pending investigation 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

al Hygiena.

permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

Examiner tha

sician and burial-transit physician Physician/Medical signed by the aid to be datached for ρ Completed has 2 Certification:

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Division of Vital Records, P.O. daath. or Attend after death Director: To the Hospital or Atte within 24 hours after dai To the Funeral Directo completely filled in by the



Registrar

Medical

29b. Signeture end title of certifier

6 Could not be determined

Lock Laven Blod

Cartifying Phyatcian: To the best of my knowledge, death occurred at tha time, date and piece, and due to tha cause(s) and manner as statad.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(a) end manner stated. 29d. Dete signed (Month, Dey, Year)

Location (Street and Number or Rurel Route Number, City or Town, State)

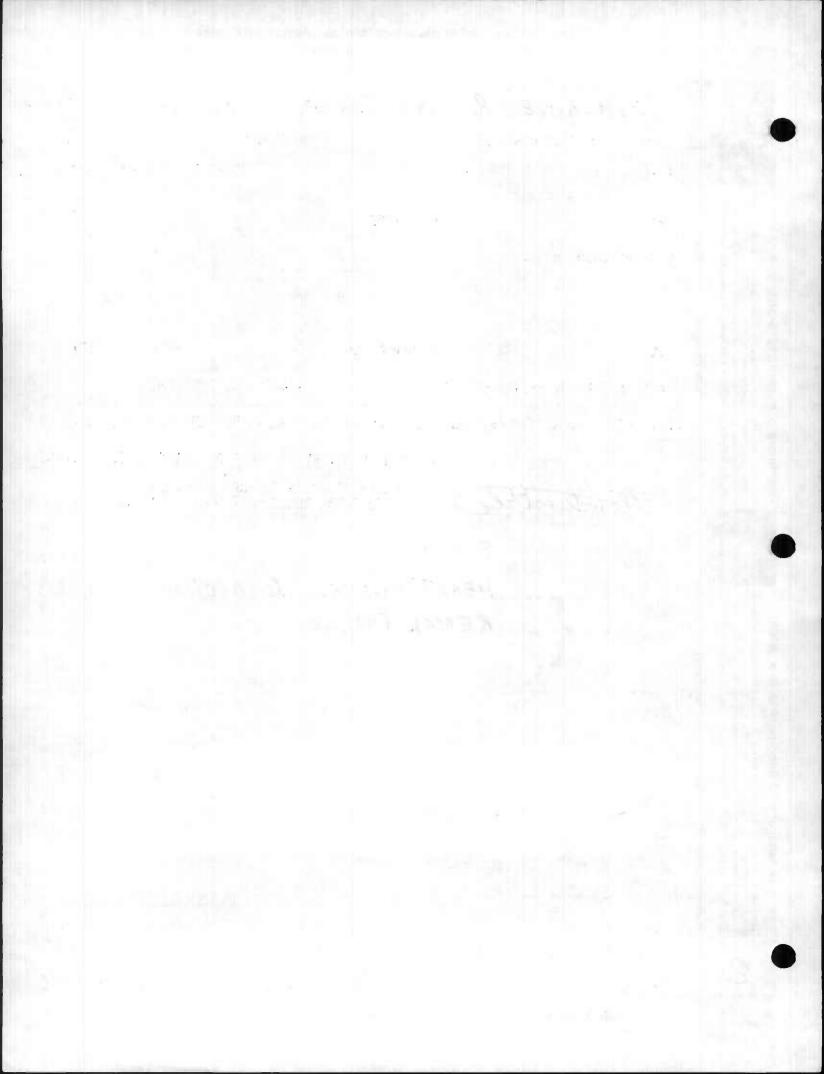
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30/-SAMAKITION HOSDITA

31. Date filed (Month, Day, Year) JUN 0 3 1998

32. Registrar's Signature Pulia Davidson

28e. Place of tnjury - At homa, farm, straat, factory, office building, etc. (Specify)

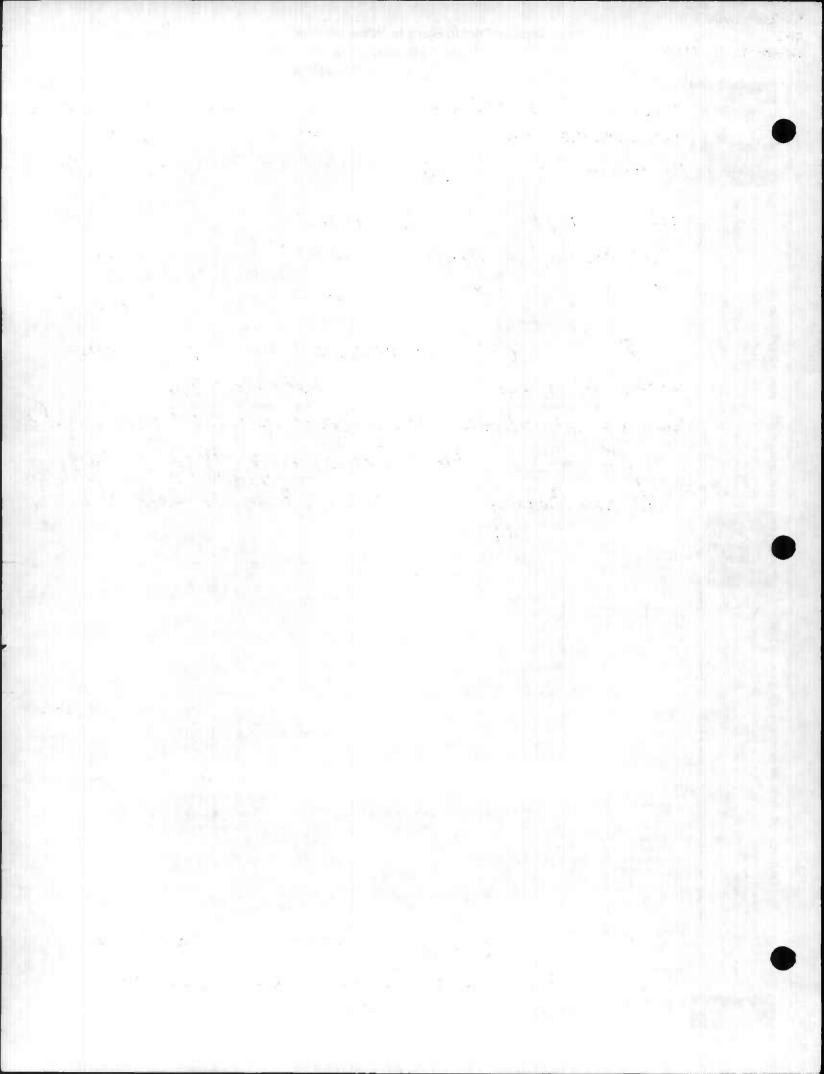


		Decedent's Name (First, Middle, I	ast)		Certific	ale UI	Dealli	2. Dete of Dea	reg. No.	8	3. Time of Deeth
Physici /Medi		EVELYN	W	ILSON				Month MAY		Year 1998	5.16 P
Examir	er	4e. Fecility Neme (If not institution, g				1	4b. City, Town, or BALT11		4c. County	of Death	
Funerai Director		5. Social Security Number 218–58–8557		ENTER Age (in yrs. last 44	birthday) If U	nder 1 Year ths Days	If Under 24 Hrs Hours Min.	8. Dete of Birt	h, Year) 5 1953		ece (Stete or Fore ry) Land
how		Usual Residence of Decedent 10a. State 10b. County			own or Location					10	d. Inside City Lim
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23a or 2 ust be n	al Dire	10e. Street end Number 223 Juniper Dri	ve		10f	. Zip Code 210	60		10g. Citizen of US	What Count SA	ry?
or items	by Funeral Director	11. Maritel Stetus 1 Never Married 21 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1	s? (No	If Yes,	ecedent of H specify Cubs es 2[X]No	lispanic Origin? (S an, Mexicen, Puerl Specify:	pecify Yes or No- o Ricen, etc.)		ce - America ck, White, e y: Whi	itc.
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ate! Hygiene. od other than event, the M	Be	17. Father's Name (First, Middle, La. Clarence J. Blu	*					ne (First, Middle, L. Frank		ne)	
f Heelth and Mentel Hyg tem 27 Is marked othe other traumatic event,	To	19a. Informant's Name/Relationship David N. Wilson	(Type, Print)	and	19b. Mailing Add	ress (Street	end Number or Av Prive Gle	ural Route Numbe	er, City or Town,	, Stete, Zip (Code)
Department of Heelth a Important: If Item 27 Is any injury or other tra <u>once.</u>		20a. Method of Disposition 1 ↑ **Buriel 2 □ Cremation 3	☐Removel from Stat	20b. Place	e of Disposition etery, cremetory r Hill ((Neme of or other pled	ce)	June 1	20c. Location	- City or Tov	
Departmer Important: any injury ance.		4 Donetion 5 Other (Spec 21. Signature of Funeral Service Lic		Leda	22. Nam	e and Addre	ss of Facility olyniak F	1998	Brookly	yn Par	ck, Md.
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physicien end s the burial-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury	0.	Due to (or as	e consequence	of):					
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s been signed by the a	Completed by							24a. Was perfo	an autopsy med?	eve	re eutopsy finding elleble prior to enpletion of ceuse leath?
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s certificate director, pag	Be	25. Was cese referred to medicat examiner?	Hospital:			Oth	one:	ath (Check only o			
th la	n: To	1 ☐ Yes 2 € NO 27. Manner of Death	28e. Dete of In (Month, L		b. Time of	28c. Injur Wor	4 LI Nursing F	fome 5 ☐ Resident 28d. Describe I)
After funer	Certification:	1	on be 28e. Place of I	njury - At home	Injury M , farm, street, fe	10	Yes 2 □ No	28f. Location (S	Street end Numi	ber or Aurel	Route Number,
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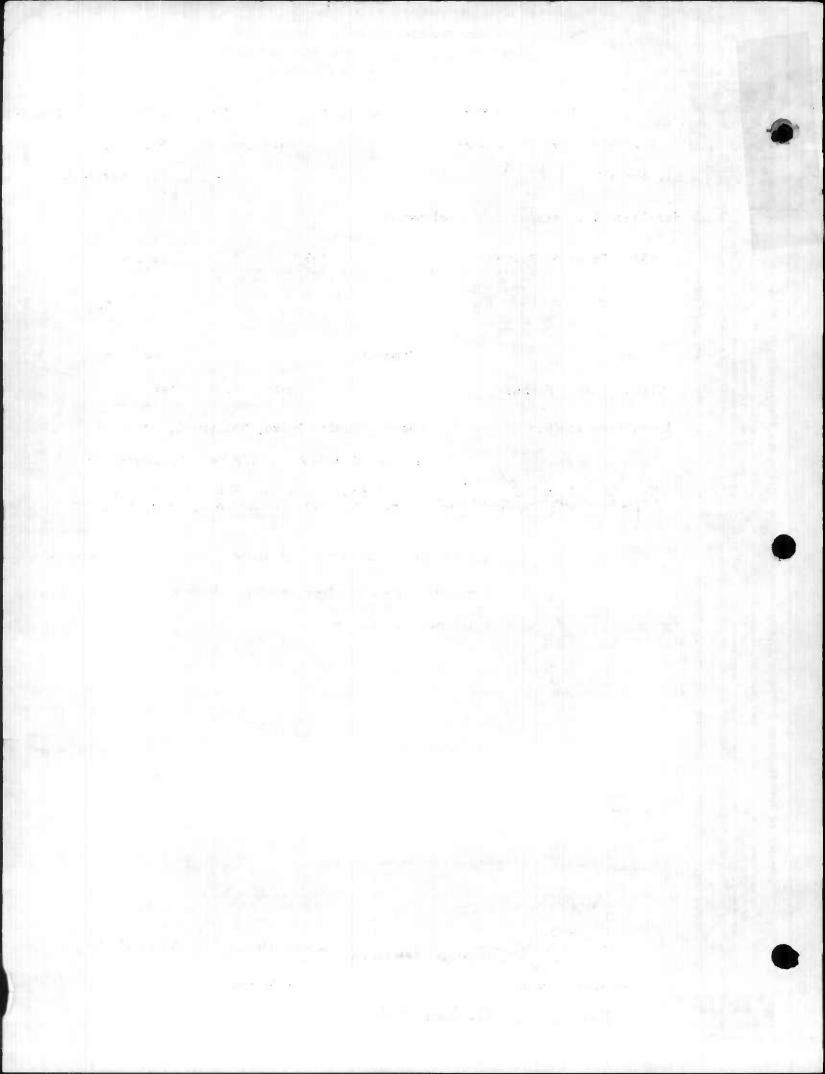
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State of Manyland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dev Month Yeer Casey 0645W S Athman May 1998 18 4c. County of Death BALTIMORE 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Systems CITY Medical University of Morylond alt more if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 100 M 2 F Months 16 219-13-0649 /22/1982 MARYLAND Usuel Residence of Deceden 10c. City, Town or Location 10d. inside City Limits 10h. County 1 Yes 2 No CARROLL WESTMINSTER 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 131 NORTH GORSUCH RD. 21157 USA. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 13. Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, etc. 1)☑ Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) STUDENT EDUCATION 10 17. Fether's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Meiden Sumeme) JOHN J. ATHMAN, SR. JOSIE BARCLAY 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) JOHN J. ATHMAN, SR.-FATHER 131 N. GORSUCH RD., WESTMINSTER, MD.21157 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ♥ Buriel 2 □ Cremation 3 □ Removal from State LEISTER'S CEMETERY 5/22/98 WESTMINSTER, MD. 4 Donetion 5 Other (Specify) 22. Name end Address of Facility FLETCHER FUNERAL HOME 21. Signature of Fuperal Servica Licensee 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart felillere. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) · Severe head closed CERTICATION SPROUD BY MERCHA Due to (or es e consequence of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probabty 4 Unknown 1 Yes 2 10 No Prelimonia 24e. Wes en eutopsy performed? 24b. Were autopsy findings avelleble prior to adult respiratory distress syndrome completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pres 2□ No

Physician /Medical Examiner

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Physician

/Medical

Examiner

10s. State

MD.

Directo

Funeral

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Funeral

Director

notifie

r than "natural", or itsms 23a or the Medical Examiner must be a

72 hours after

parmit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiens, important: If item 27 is marked other than 1

altimore, Maryland 21215-0020

physicien end the buriel-transit 98 use ed by the deteched page 2 s certificate

funeral

certificate be executed Box 68760 P.O. Division of Vital Records, this After efter death. the filled in by

Physician/Medical by Completed Be 10 Certification:

Examiner

Hospital or Attending 24 hours within 24 hor To the Fune completely fi

> State Registrar

5 Pending Investigation

6 Could not be

29c. License number

28c. Injury et Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Dey, Year)

by car while rollebladding

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Gorsuch Ed ERte 140 Westminster

28d. Describe how Injury occurred

AS2402321PG 9024 May 18, 1998

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) UND Green University

22 S. Greene Street Medical Sys

Maryland 21201 Baltone

31. Dete filed (Month, Dey, Year) MAY 2 0 1998

29b. Signeture end title of cartifier

27. Menner of Deeth

1 Neturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homlcide

(Check only

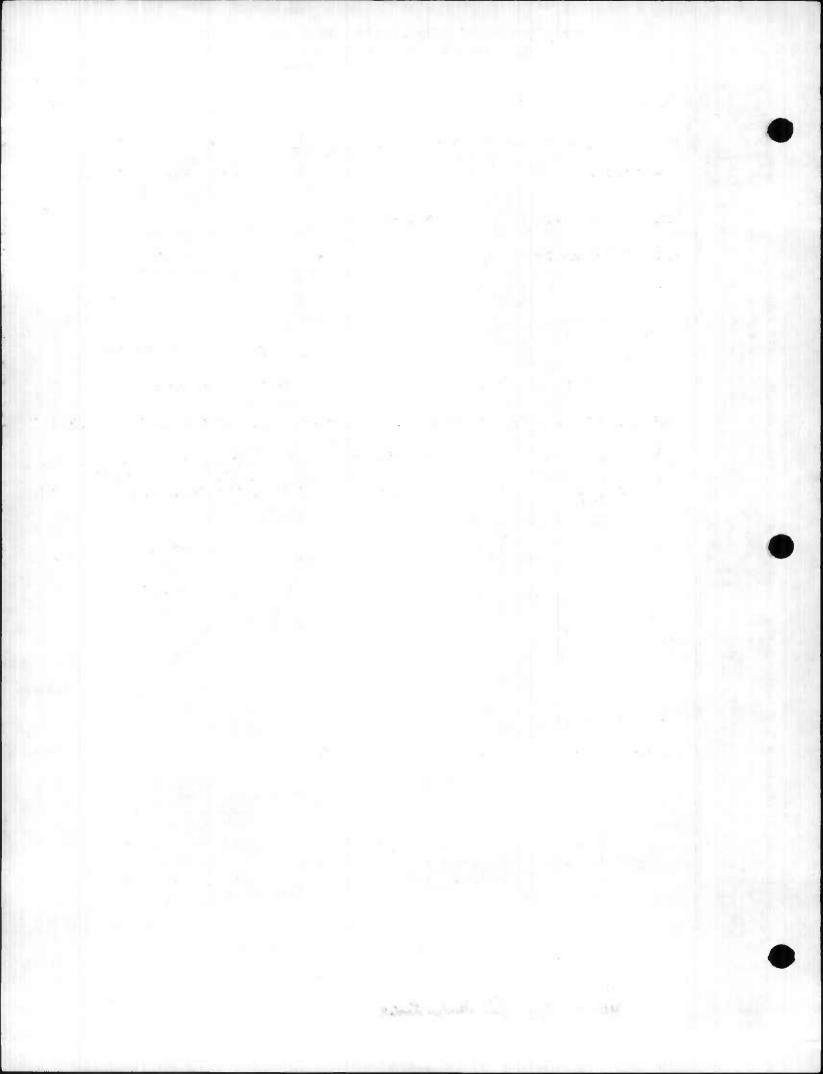
28a. Date of Injury (Month, Dey Year)

Street

May, 14,1998 19028

28b. Time of

28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 258 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Year 5.40 AM MARION BOWLES MAY 281 1998 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE CHEVERLY PRINCE GEORGE HOSPITAL CENTER 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) Deys 1 □ M 2 🖫 F December 27, 1923 Washington, DC 579-40-2109 Usuel Rasidence of Deceder 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yas 2 No Maryland | Prince George's Clinton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20 735 8600 Mike Shapiro Drive U.S.A. 14. Race - Amarican Indian, 12. Was Decedent Evar in U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Meritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Giva Yaer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Grocery Store 8th Meat Wrapper 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Lydia W. Suit Joseph Plowden Hill 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Steta, Zip Code) P.O. Box 113, Loveville, MD 20656 Brenda Guy/Daughter 20b. Place of Disposition (Nerna of cametery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burlei 2 Cremetion 3 Ramovel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Charles Memorial Gardens 6/1/98 Leonardtown, Maryland 21. Signetura of Funaral Sarvice Licenses 22. Nama end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. 23a. Part I Enter the disease, or consplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approxished, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Daeth Immediete Ceuse (Finel REMAL FAILURE disaesa or condition resulting in deeth) Examiner Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Denknown Cerebrovascular Accident. Respiratory failure 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? completion of cause of deeth? DIASELA Mellitus Brain Mass 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dimpatient 2 □ ER/Outpatient 3 □ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Physiclan/Medical p Completed

Be

10

Certification:

Medical

physicien end s the burial-fransit ettending pl signed by the e should certificate has t funeral Hospital or Attending Pi 24 hours efter death.
 Funerel Director: After ti

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

th and Mentel Hygiene.
7 is marked other than "naturel", or items 23s or traumetic event, the Medical Examiner must be

or other t

permit. Pege Department of Important: If eny Injury or once.

Physician /Medical

Examiner

that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Peges 1 end 2 should be filed within 72 hours after nent of Heelth and Mentel Hygiene. Int: If item 27 is marked other then "naturel", or ite

Baltimore, Maryland 21215-0020

the Marylend or 28a-f show

with

death

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 Homloide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier Xhow

N. Ashai

M.D

29c. Licansa number D48213 29d. Dete signed (Month, Dey, Year) 5-29-98

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

4000

220 BOWIE MD 20716

State Registrar

31. Dete filed (Month, Dey, Year)

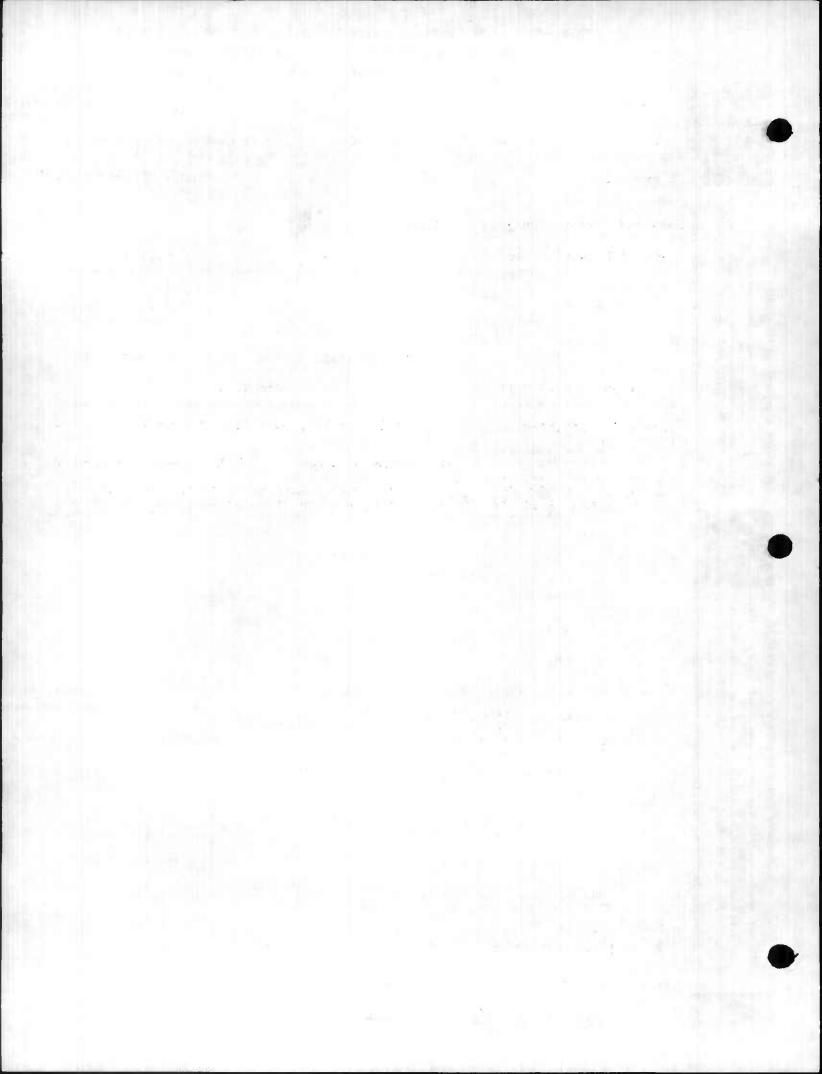


RO

Miletelville

24 hours

To the Hosp within 24 ho To the Fune completely fi



Funeral Director 28a-f show ns 23a or 28a-f si , or items 'natural',

1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth May Dey 1998 Yee **Physician** Gilbert A. Bitzel 16 12:05pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 3860 Sykesville Road Sykesville Carroll 7. Age (In yrs. lest birthday) 5. Social Security Number 214–16–1134 If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) May 9, 1921 Birthplece (State or Foreign Country) 1 X M 2 □ F Months Deys Hours Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Carroll Sykesville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3860 Sykesville Road 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11 Marital Status 14. Rece - American Indian. Bieck, White, etc. filed within 72 hours after 1 Never Married 2X Married 1 X Yes 2 □ No WWII altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) textile permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If Item 27 is marked other that any Injury or other traumatic event, Iffall once. weaver 10 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be George R. Bitzel Elizabeth Conaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ellen Bitzel (wife) 3860 Sykesville Road Sykesville, Md. 21784 20b. Place of Disposition (Name of cemetery, cremetery or other place)

Carroll Cremation Serv. 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 🌠 Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 5-19-98 Hampstead, Md. 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784 23a. Pert1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** SEPSIS WITH immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner PNEUMONIA physician and s the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): (CONGESTIVE CARDIOMYCHATHY) END STAGE HEART DISKASE P.O. Box 68760, Physiclan/Medical Due to (or es e consequence of): ORONANY ARTERY DISEAJE signed by tha a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, þ cata has been sig, page 2 should b Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 20 No Division of Vital Mospital or Attending Physician: 124 hours after death.
 Funeral Director: Attar this certifical letaly filled in by the funaral director, p. 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

| Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and menner steted. 29a. Certifier To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signeture and title of continer 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) MICHARL LANSING, MJ 20 CAOSSREADS DR, SUITE 14 QUINCS MILLS, MD ZIII7

State Registrar 31. Date filed (Month, Day, Year)

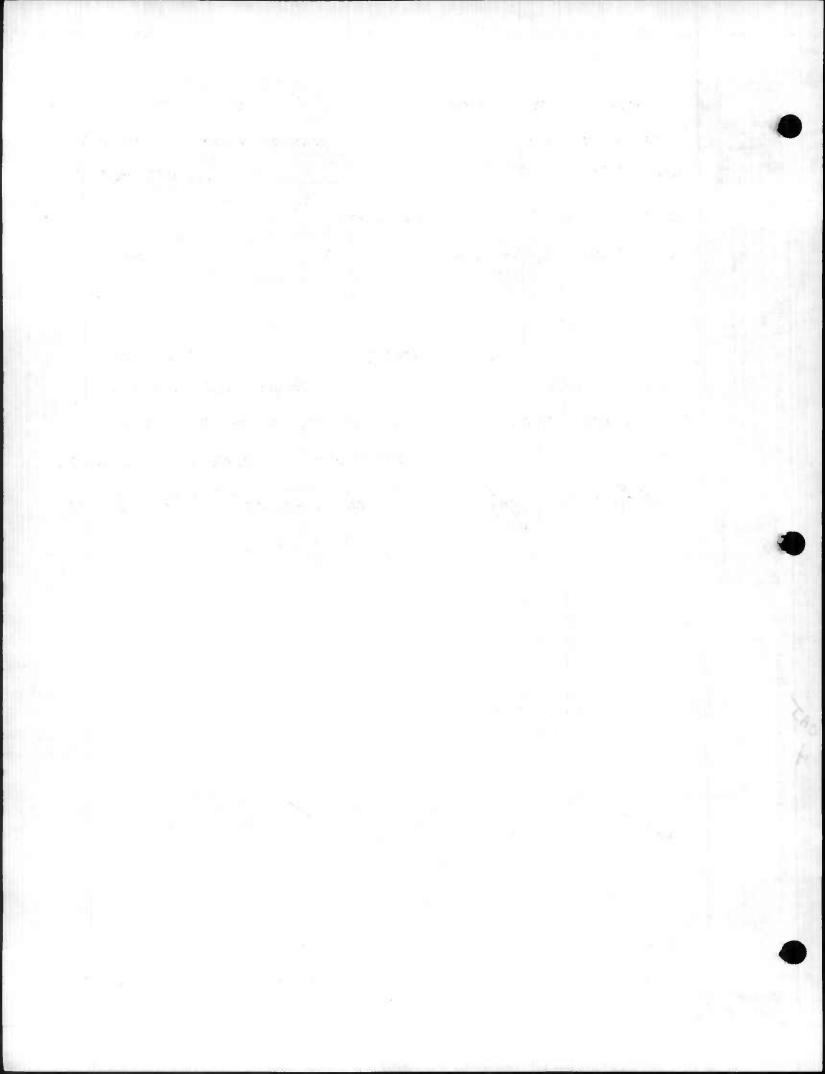
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32. Registrer's Signeture

Juki Shvidson Randall

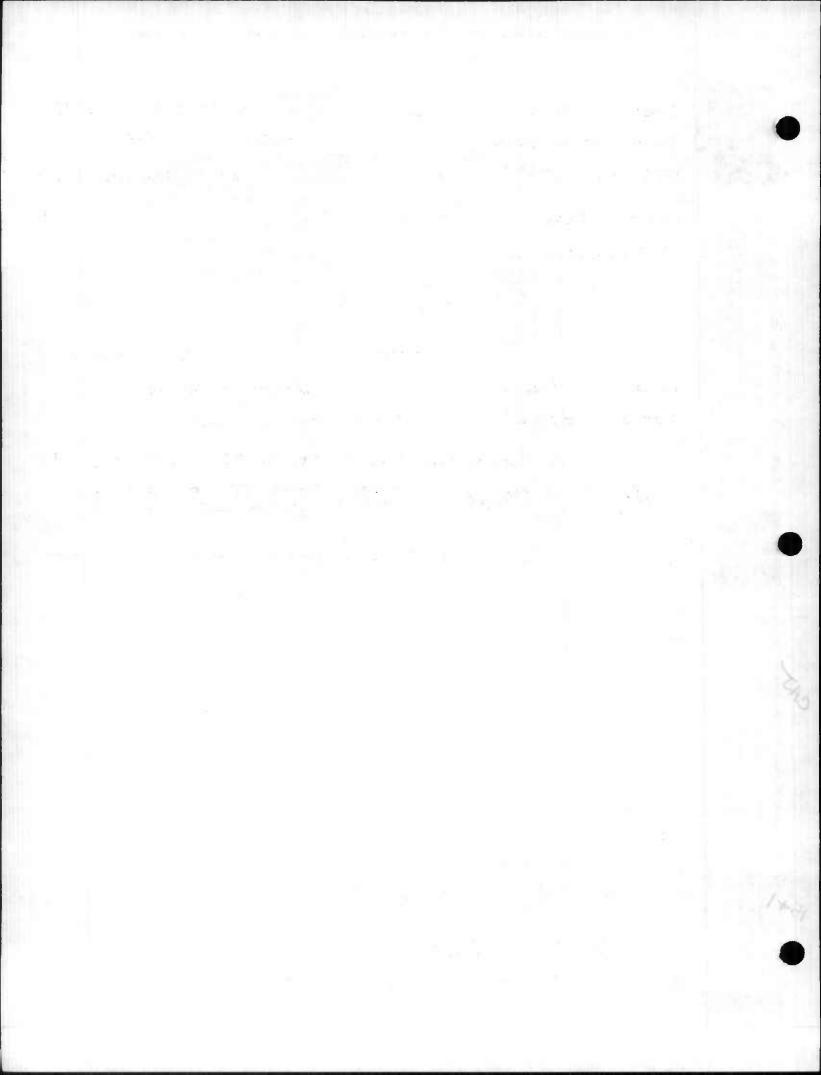
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						Ce	rtificate o	f Death		Reg. No.		
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н	Funeral		The state of the s	6. Sex 1 ☐ M 2 🙀 F	7. Age (In y	rs. lest birthday)	if Under 1 Year Months Day		lin. (Month, E	irth Pa <i>y</i> , <i>Year)</i>	9. Birthp	place (Stete or Foreign
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Maryland 21215-0020	el', or h	þ	1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	ed 1 ☐ Yes If Yes, Gi Year or D	ve		1□Yes 2⊠N			Specif		
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lai	should be nd Mental marked o	To E	George W. Schm	idt				Marq	aret (UK) Schab	dach	
ary	2 should end Men is marke eumatic		19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Maili	ng Address (Stre	-				Code) 21078
	D = C =		J. Frank Brown	III/Son					m Road,			
ē,	Health tem 27		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b	. Place of Dispo	sition (Name of		Date	20c. Location		
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۴.	/Medical Examiner		tmmediate Cause (Final disease or condition	a. Con	gesti	ve t	tear	faul	we		ti	and you
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Ž	rect d	Ę.	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place	of injury - At	home, farm, str	eet, factory, office	a		(Street and Numilian, Stete)	er or Rura	l Route Number,
	o les la la la la la la la la la la la la la	Cer			and the second	,,				,,		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ig Ca	29a. Certifier 1 Certifying	Physician: To the	best of my kr	nowledge, death	occurred at the	time, date end pia	ce, and due to the	cause(s) and ma	anner as si	ated.
	in 24 he Fi	edicai	one) 2 medical Ex	kaminer: On the ba and man	ner stated.	netion end/or inv	estigation, in my	opinion, deeth oc	curred at the time	, dete end place,	and due to	the ceuse(s)
	With:	Σ	29b. Signature end title of certifier				29c. Lice	nse number		29d. Date signe	d (Month,	Dey, Year)
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				State of W	alylalia / i	Certific		ieaith and iv Death		eg. No.	0 1	12.01
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Dete of Deer Month		Yaer	3. Time of Death
	Physici /Medi		Edward EUG		Bi	rd, Jr			May 19,	1998	1201	10:15 AM
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	Funeral Director			X M 2□ F	ge (In yrs. last bi	Yrs. Mont		Hours Min.	8. Date of Birth (Month, Day) Dec. 2.	Year)	9. Birthpi Coun Penr	lece (Stete or Foreign try) ISylvania
	wo m		10a. State 10b. County		10c. City, Tow	n or Location					10	Od. Inside City Limits
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	or 28	Sire	10e. Street end Number			10f.	Zip Code		1	0g. Citizan of \	Whet Coun	try?
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20	permit. Pages 1 end 2 should be filed within 72 hours effer deeth with the Marylend Department of Health end Mental Hygiene. Important: if item 27 is marked other than "naturet", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Merried 20 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 ☑ Yes 2 ☐ if Yas, Giva	No 1948		cedent of Hi specify Cuba s 25 No	ispenic Origin? (Spenn, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e	etc.
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Maryland 21215-0020	end 2 st ealth end n 27 is m		19e. Informent's Neme/Relationship (7) Kathryn M. Bird/V					end Number or Rura Road Sout				
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			30. Nema and address of person who co	mpleted cause of d	leeth (Item 23e)	(Type, Print)	500	r Ave	RA-	10.	0 -	
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Month Day 05 19 1998 Alsace Lorraine Brown 6:37pm 4a. Fecility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 24 Hrs. If Undar 1 Yaar 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) Months Davs 1 □ M 2**/**2 F Hours Yrs 213-46-3848 83 09/13/1914 England Usual Rasidanca of Dacedani 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 XNo Harford Darlington 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1940 Nobles Mill Road 21034 USA 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 Û No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, atc. 11. Maritel Status 1 Never Marriad 2 Married 1 ☐ Yas 2 💢 No Specify 3 Widowad 4 Divorcad White 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 4 Teacher School 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Walter C. Drake Elizabeth Brooks 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 1940 Nobles Will Rd Darlington, MD Louis Brown- Husband 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) R.A. Ferris & Co. Inc. 5/22/98 West Chester, PA 21. Signatura Funaral Sarvica Licansas 22. Nama and Addrass of Facility Mitchell-Smith Funeral Home, P.A. 23a. Part1. Entar the diseasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 123 S. Washington St. Havre de Grace, MD Approximata Intarvai Batween Onset end Daath Immediata Ceusa (Final disaasa or condition resulting In daath) AMYPHALA 5 HUUNG Dua to (or es e consaquanca of): CONCESPUE INGENT 13 You MILLURE Due to (or as a consaquanca of): AMIA FISTILLADON 13 4 ms Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona)

Physician /Medicai Examiner

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certificate

After this funeral

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24 hours

To the within 2

Physician/Medical Examiner

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r than "natural", or itema 23a or 28a-1 show the Medical Examiner must be nothed at

Pages 1 and 2 should be filed within 72 hours efter deeth viewt of the state and Mental Hygiene.
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permit. Peges Depertment of h Important: If its any injury or o once.

Baltimore, Maryland 21215-0020

May 19, 1998

Brown, Alsace Lorraine

with the Marylend

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting In daath) Last

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRUSIC OBSAUCAN (VUTGIAMY PISITE

25. Was casa rafarrad to madical examinar? Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA

27. Mannar of Death 28a. Data of Injury (Month, Day Year) 1 Natural 5 Panding invastigation 2 Accident 6 Could not ba 3 ☐ Suicide

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

28b. Tima of 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifian (Check only one)

29b. Signatura and titla of certifiar

31. Data filad (Month, Day, Yaar)

4 Homicida

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Data signad (Month, Day, Yaar)

30. Nama and addrass of person who completed cause of death (Ham 23a) (Type, Print)

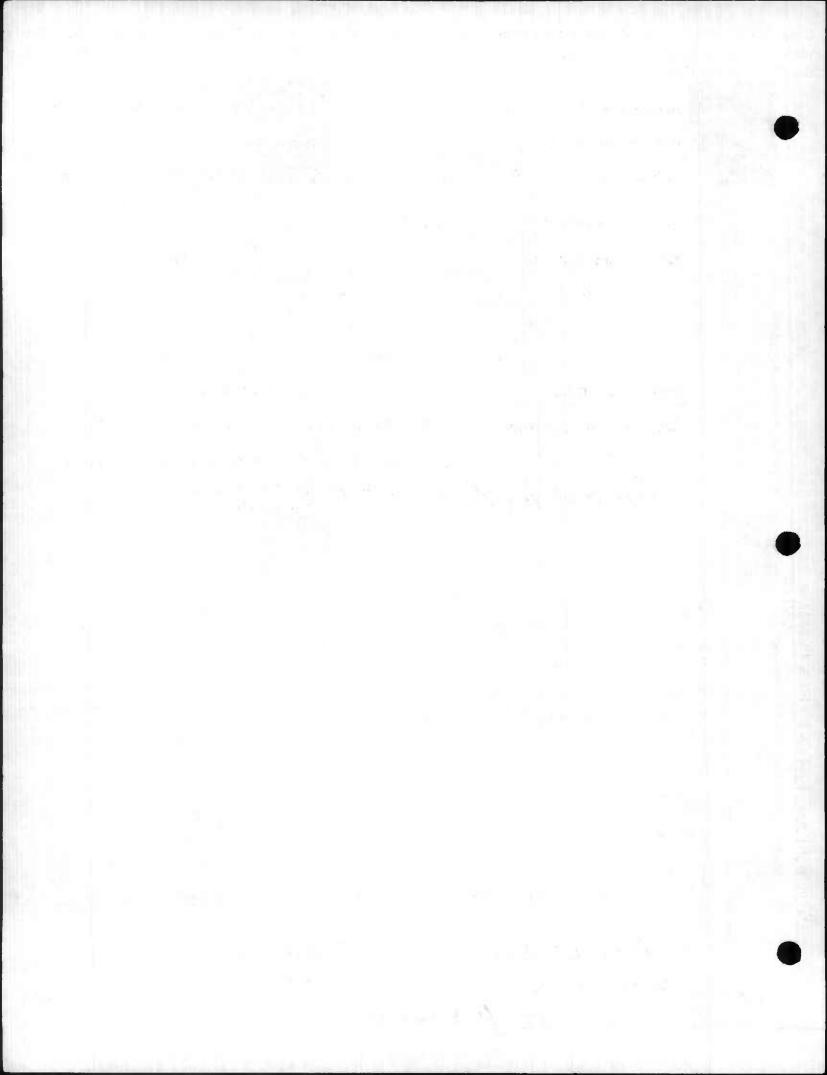
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State Registrar





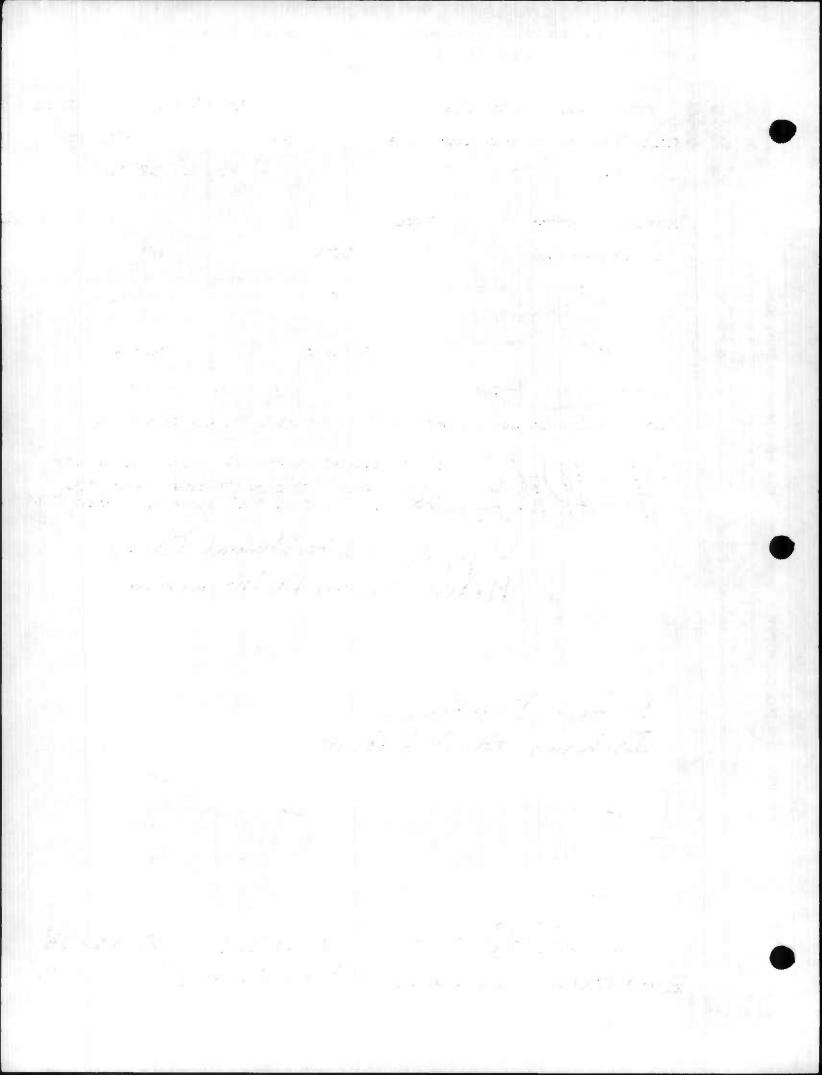
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death May 16, **Physician** 1998 5:15 PM Avis Loine Bainbridge /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Baltimore Cromwell Center- Genesis Health Care Towson 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Mar. 10, 1927 Virginia 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 1 M 20 F Months Hours Director 220-20-7931 71 Usual Rasidance of Dacedant the Marylend 10c. City, Town or Location 10e State 10h Counts 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Director Harford Maryland Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examinat must be not any injury or other traumatic event, the Medical Examinat must be not any injury or other traumatic event, the Medical Examinat must be not any injury or other traumatic event. 21085 IISA 3520 Clayton Road Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Cregger 10 Mary Emily Emmett James 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 3520 Clayton Road, Joppa, Maryland 21085 Jerry W. Bainbridge, Sr./Husband 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other Spec Bel Air Memorial Gardens 5-20-98 Bel Air, Maryland of Funeral Se 22. Nama and Addrass of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009
la death. Do not anter the mode of dying, such as cardiac or respiratory arrest,
Approximate Approximata Intarval Batween Onsat and Death Gdytromberland Bleed **Physician** /Medical immadiata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner physician and the burief-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated evants rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of) S 980 23b. Did tobacco use contribute to the ceuse of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has certificate 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director, Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Othar: 6 Rasidanca 8 Othar (Specify) 1 Yas 2 → No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 1- Natural 5 Panding after death. Director: Aft 1 ☐ Yas 2 No Invastigation 2 Accidant 6 Could not be datarmined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 24 hours a Funeral C Hospital 29a. Cartifiar edicai 🖅 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the I within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of 29c. Licanse number 041901 30. Nama and address of person who complated cause of death (Itam 23a) (Tupe, Print) or them Parkway, Baltimore, Mas 10 am psrim 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State

State Registrar

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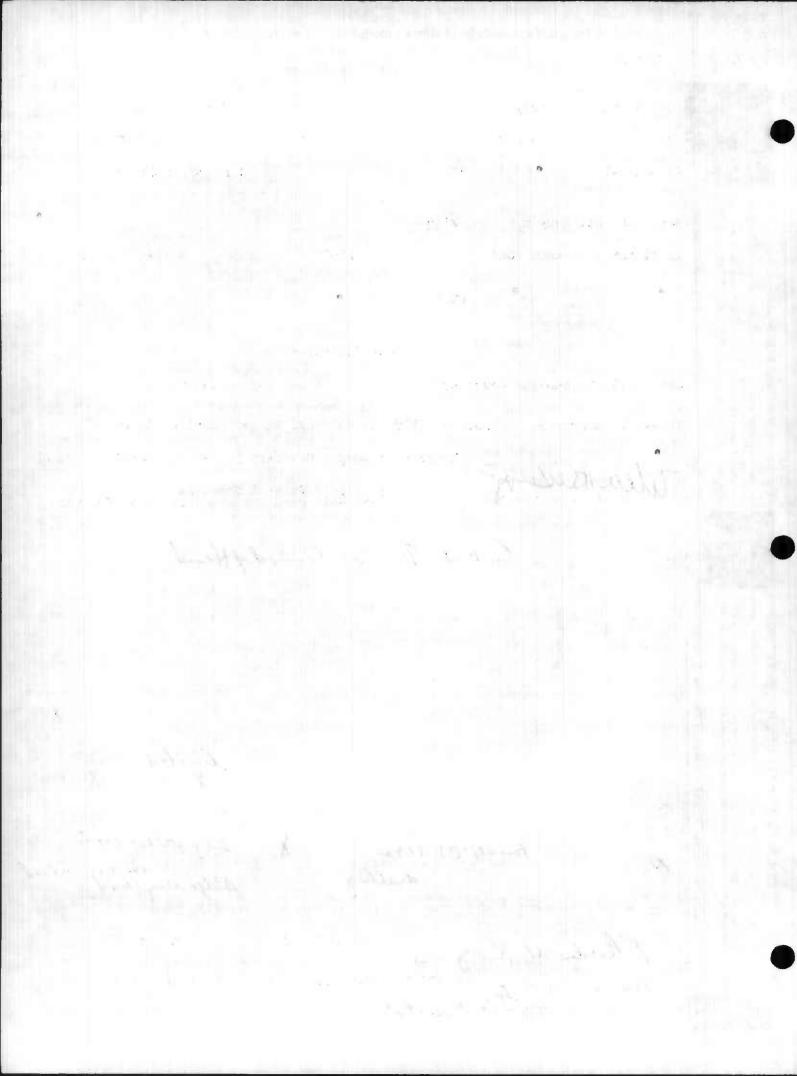
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State of Maryland / Department of Health and Mental Hygiene

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DAVID LO	UIS	S COURTNEY		State of h	nai yiai i	-	tificate of	Death		Reg. No.		1264
Dhysisi		1. Decedent's Neme (First, I							2. Dete of Der Month	eth Dey	Year	3. Time of Death
Physicia Medic/		David Louis	Cour	tney					MAY	3, 1998		1320 PM
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			-	AVEN LANE			7(1)=1-7 (2)=	RIDGE			IARY '	
Funeral Director		5. Sociel Security Number 219–42–3972		Sex 7.7 1 ■ M 2 □ F	Age (In yrs. I	last birthdey) Yrs.	If Under 1 Year Months Deys	Hours Min.	8. Date of Bird (Month, Da June 20	y, Year)		olece (State or Foreign otry) yland
aryland		Usual Residence of Deceder 10e. State 10b. Co	unty		10c. City	y, Town or Lo	cation				1	10d. Inside City Limits 1 ☐ Yes 2 ■ No
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th with t	Funeral Director	10e. Street and Number 13931 Point I	ooko	ut ROad			10f. Zip Code 2068	0		United		
Maryland 21215-0020 d 2 should be filed within 72 hours aftar death with the Maryland th and Mental hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinations to or 1	by	11. Maritef Stetus 1 ■ Never Married 2□ 3□ Widowed 4□ Divo		12. Wes Deceder Armed Forces 1 Types 2 [If Yes, Give Yeer or Detes	s? ∃No \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Nes Decedent of If If Yes, specify Cub I ☐ Yes 2 ■ No	dispenic Origin? (Si en, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)	Specify	ck, White,	can Indian, etc.
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o H o H		1 Buriel 2 Creme 4 Dogetion 5 Oth					netory or other ple piscopal	Cemetery	5/7/98			
Baltim permit. Pa Departmen important: any injury pnce.	-	21. Signature of Mayoral Mis	Toe Date	Louis			. Neme end Addre				7	,
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Geath cardeath card a strending of for use	Physician/N	Pert II. Other significant cor	ditions		but not resu	ulting in the u	nderlying cause giv	ven in Pert i	23b. Dld	tobacco use co	ntribute t	o the cause of death?
that the ded by the detached	/ Phys											bably 4 Unknown
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r Vital Re ysician: Tha is s cartificata he director, paga	e C	25. Wes case referred to me	dical					26. Place of Dec	eth (Check only o	one)		
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Hosp 24 hos Fune felly fi	edicai	29a. Certifier (Check only Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause.)										
DIN To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	September 1	one) end manner steted. 29c. License number								29d. Dete signe	d (Month.	Day, Year)
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2. Date of Death

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30	Funeral Director		5. Social Security Number 6. S		e (In yrs. last bir 87		If Under Jonths	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D January		9. Birth Cot	pplace (State or Fore intry) cyland	oig
	how		10a. State 10b. County		10c. City, Tow	n or Local	tion							10d. Inside City Lim	its
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Ma	and 2 s selth an n 27 ls i		Catherine Dunn/Da									oer, City or Town		p Code)	
re,	f Hee		20a. Method of Disposition	Method of Disposition				ne of	Avenue, Hyattsville, MD 207					own, State	
m	Peges 1 nent of h snt: If ite ury or ot		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		St. Ge					5/	20/98	Valley	Lee,	MD	
Balt	permit. Peges 1 and 2 Department of Heelih s important: if Item 27 is any injury or other tra once.		21. Signalore of Funeral Service Lice	Laster Sander		Ma	ttir	ngle		dine		ral Home		Α.	
	4		23a. Pert1. Enter the disease, or comshock, in heart tailure. List only	plications that caused one cause on each li	the death. Do i	not enter t	the mode	e of dyln	g, such as	cardiac o	r respiretory	arrest,		Approximata Intarvei Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	· uRo	SEPS	15								Onset and Death 48 HPS	
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,00	deeth certificate be executed e ettending physician and d for use es the bunel-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury	b	Due to (or as a	consaqua	nce of):								
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State Registrar

31. Date filed (Month, Day, Year) MAY 18 1998

Anil K. Shah,

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

MD

1. Decedent's Name (First, Middle, Last)



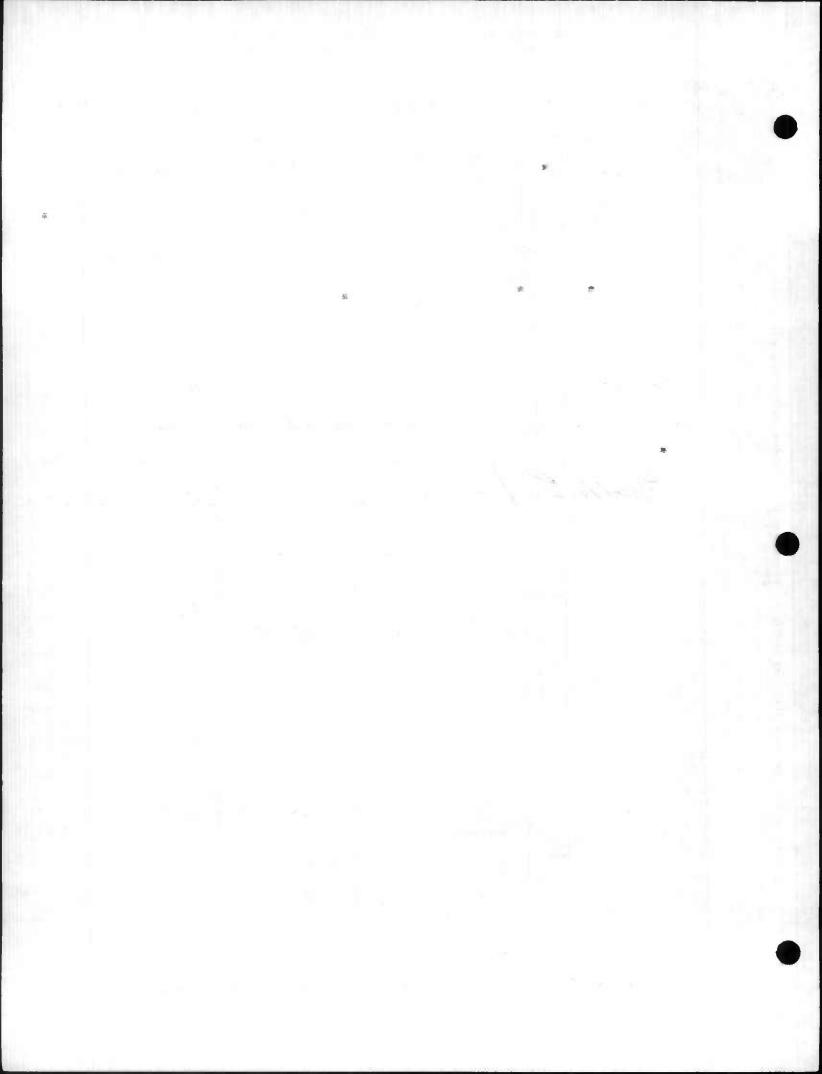
Leonardtown, MD 20650

Cutchember, C Catherine

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ANTHONY VICTOR CAPECE MAY 18, 1998 11:55 AM /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 14, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** Days Hours 1 ■ M 2 □ F 055-01-8048 78 Yrs June Director 1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner mantice inclined at 1 ☐ Yes 2 ■ No Maryland St. Mary's Directo California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23233 Town Creek Drive 20619 United States deeth Funerai permit. Pages 1 and 2 should be filled within 72 hours effer deet Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than any injury or other trainments. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - Americen Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1943-1945 1 Never Married 2 Married 1 ☐ Yes 2 ■ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Vito Capece Nancy Marie Capece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agatha Capece, Wife P.O. Box 435, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Buriai 2 □ Cremation 3 □ Removal from State MD Veterans' Cemetery 5/26/98 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Juneral Service Licen 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 M00052 ield, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Caprat Examiner Due to (or as a consequence of): Examiner pital or Attending Physicien: The law requires that the death certificate be executed ours effer death.

eral Director: After this certificate hes been signed by the ettending physician end illied in by the funeral director, page 2 should be deteched for use as the buriar-transit filled in by the funeral director, page 2 should be deteched for use as the buriar-transit Sequentially list conditions, it any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Endstag Physician/Medical Due to (or as a consequence of) signed by the ettending a be deteched for use es Part ii. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence & Other (Specify) Subacci 1 Yes 2 No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 41.1 1 XNatural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Mospital 24 hours e Funeral C Medicai 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier To the Hosp within 24 hou To the Fune completely fi 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jonathan D. Lowenthal, M.D., Prince Frederick, Maryland 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Jalia Davidson Rardall Registrar MAY 22 1998



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month **Physician** May 21, 1998 Callan 8:40 PM Martin P. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not Institution, give street and number) Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year Birthplace (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days 100 M 20 F Yrs. 93 Director 222-03-2157 January 15, 1905 Pennsylvania Usual Rasidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprines must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Directo Maryland St. Mary's Leonardtown 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda Funeral 419 Cedar Lane Apartments 20650 U.S.A. 14. Race - American Indian. Was Decadant Evar in U,S. Armad Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritel Status Black, Whita, atc. 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 Yas 2 No Specify: g 3 □ Widowed 4 □ Divorced White Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4 Years Director of Public Works U.S. Government 17. Fathar's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) Be Michael Callan Unknown 19e, Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Numbar, City or Town, Stata, Zip Coda) 94109 1000 North Point Street, Apt. 1402, San Francisco, CA Barbara Luby/Daughter 20b. Placa of Disposition (Name of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cramation 3 Ramovat from Stata 4 ☐ Donation 5 ☐ Other (Specify) 5/26/98 Cheltenham, Pennsylvania Holy Sepulchre Cemetery 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270 Leonardtown, Maryland 2

Content that disaasa, or complications that caused tha deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, or heart failure. List only one cause on each line. 20650 Intarvat Batween Onsat and Death **Physician** /Medical Immadiate Ceuse (Finel disease or condition resulting in death) ulmmary **Examiner** Physician/Medical Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, taading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated events rasulting in daath) Last (or as a conseque Due to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 3 Probably Unknown 1 Yes 2 No menlia by 24b. Wara autopsy findings available prior to been si Completed 24e. Was en autopsy performed? completion of cause of death? of death? is certificate has director, page 2 1 Yas 2 No 25. Was case rafarrad to madical axaminar? Be 26. Placa of Daath (Check only ona) To Other: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA After this funeral 28a. Data of Injury (Month, Day Year) 27 Mannar of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 XNeturel 5 Pending invastigation 1 ☐ Yes 2 ☐ No death. Director: A 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete) 28a. Placa of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 6 4 Homicide • Funeral Direction of Filler of Funeral Direction of Filler of Fi 1 Cartifying Physician: To the best of my knowledge, daeth occurred at tha tima, dete end place, end due to the cause(s) and mennar es stated.

2 Medicat Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and mannar stated. Medical 29a. Certifier (Check only one) To the To the To the I 29b. Signature and title 29d. Data signed (Month, Day, Yan 30. Name and addre

Leonardtown, Maryland 20650

Registrar

The law requires that the death certificate be axecuted

Physician:

or Attending

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

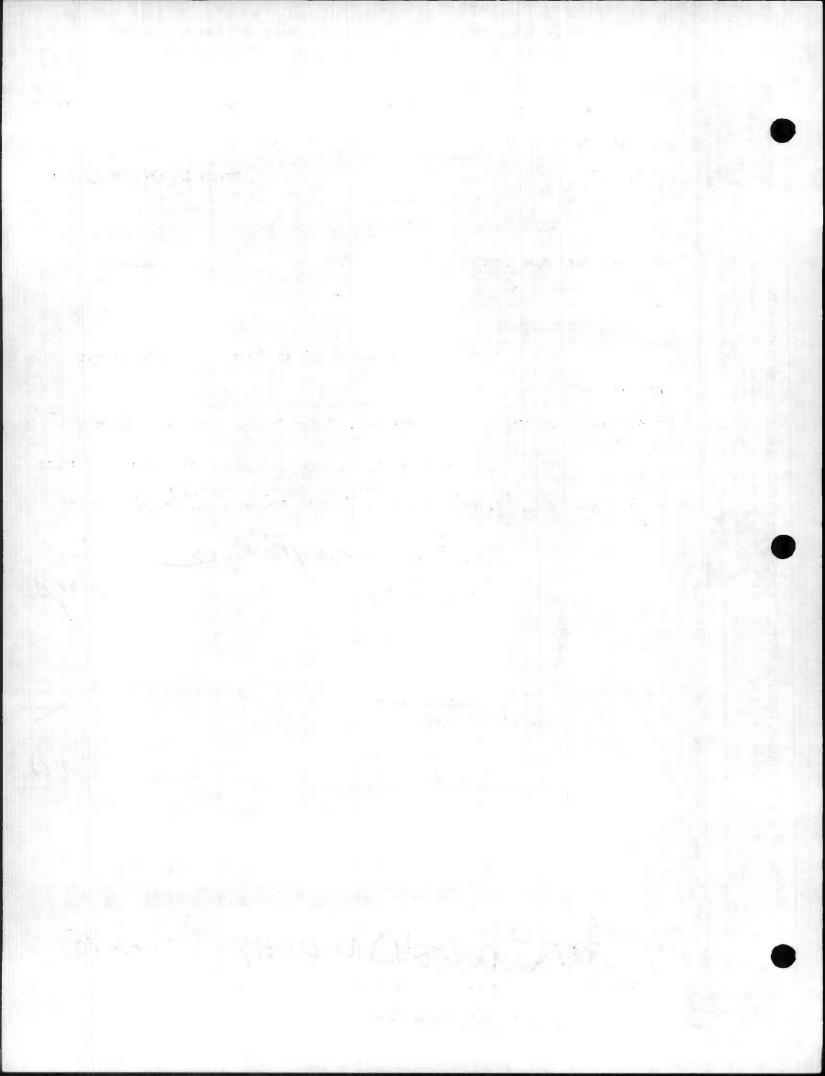
DHMH 16 Ray 6/95

Patrick Jarboe

Ragistrar's Signatura

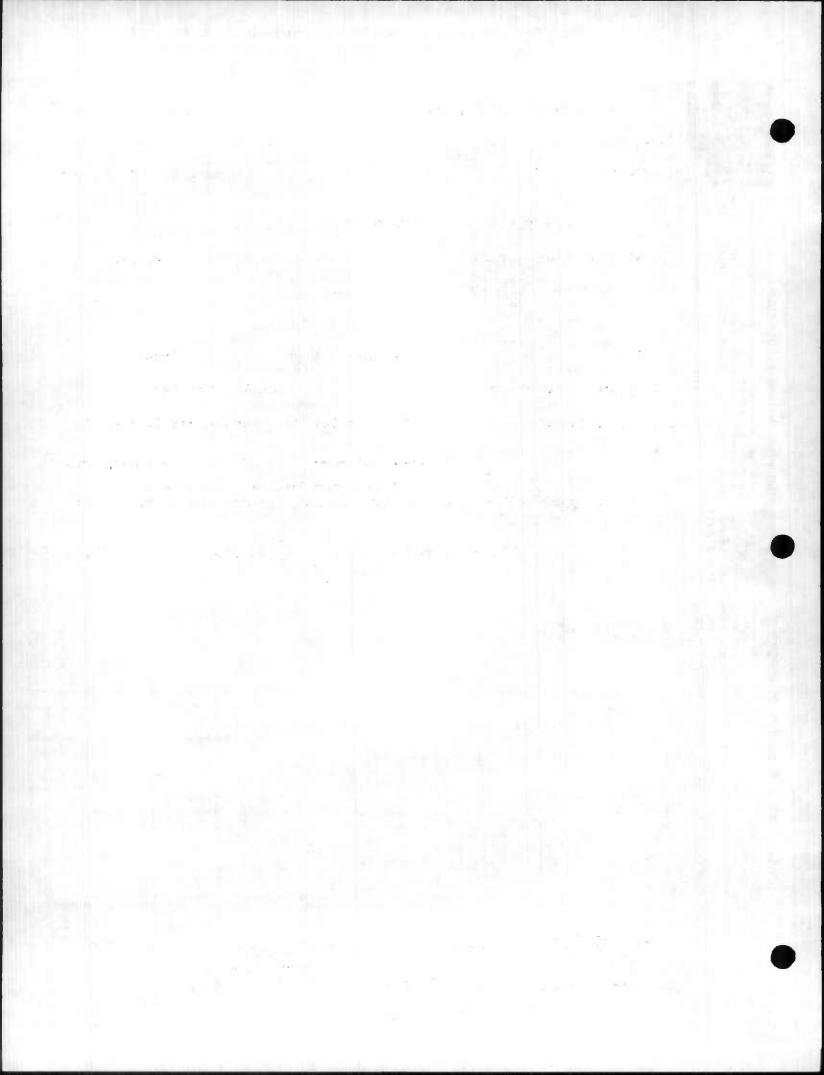
Jalia Davidson Rardall

31. Date filed (Month, Day,



State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate d	of De	eath		Reg. No.	0 1	1268
		_	1. Decedent's Name (First, Middle, I	ast)						2. Date of De		Vana	3. Tima of Death
П	Physician	-	Frank Alex	ander Comb	s. Sr.					Month May 24	Day 1998	Year	11:40 PM
	/Medical Examiner		4a Facility Name (If not Institution, g					4b.	City, Town, or	ocation of Deat		y of Death	11110 111
	Examiner		25445 Point Loo		,			T	eonard	t o vm	St	Mary	1 c
ŀ	-				ge (In yrs. last b	irthday	If Under 1 Ye	1	f Under 24 Hrs				
	Funeral Director		213-22-1162	1 □X M 2□ F	84		Months Da	ays	Hours Min.	8. Date of Bir (Month, De Novembe	r 20, 191		place (State or Foreign ntry) aryland
	pue *	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, Tov	vn or L	ocation						10d. Inside City Limits
	23a or 28a-f ahow												1 ☐ Yes 2 ☑ No
	No No No No No No No No No No No No No N			lary's	Le	ona	rdtown						**
	or 2	5	10e. Street and Number				10f, Zip Cod	de			10g. Citizen of	What Coul	ntry?
	23a 23a	Ü	25445 Point Lo	okout Road			206	550			U.S	S.A.	
	iter death with the Ma r terms 23a or 28a-f a river must be nour as		11. Marital Status	12. Was Decedent Armed Forces		13.	Was Decedent	of Hisp Cuban.	anic Origin? (S Mexican, Puer	pecify Yes or No o Rican, etc.)	- 14. Ra	ce - Americack, White,	
21215-0020	Lis a	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 I	ζNο		1□Yes 2□X				Speci	ify:	ite
0	ed within 72 hours ygiene. er than "netural", rt, the Modest Ex Completed by	3	15. Decedent's	Education	168	. Dece	dent's Usual Oc	cupation	on ,	4.1	16b. Kind of 1		
215	be filed within 72 ho litel Hygiene. d other than "nature event, the Modical Be Completed	2	(Specify only highest of Elamantary/Secondary (0-12)	rade completed) Collaga (1-4or	54)	life.	kind of work do DO NOT use re	one dur etired)	ing most of wo	King			
21	should be filed within od Mentel Hygiene. marked other than imatic event, me M. To Be Comp	5	12 th	Collaga (1º40)	34)	Ir	surance	e Ag	ent		Insur	ance	
	be filed Hyge d other event,		17. Father's Name (First, Middle, La	st)				- 40		ne (First, Middle			
a	2 should be for and Mentel It is marked of reumatic even		Benjamin Jose	ph Combs					Luc	ille Cam	alier		
2	2 should and Mer is marks aumatic	- -	19a. Informant's Name/Relationship		19	h Maili	na Address (Str	reet and		ral Route Numb		n Stata Zii	n Code)
Maryland	N 60 60 2		Dorothy V. Comb							dtown,			
	of Health Hem 27 I	+	20a. Method of Disposition	s/spouse	20h Place		osition (Name of		Leona	Date Date	20c. Location		
Baltimore,	2 5 2	1	1 Burial 2 Cremation 3	☐Removal from State	comete	ery, cre	matory or other	place)	1	Date	200. Location	- Only of 1	Jimi, Glate
Ë	permit. Page Department of Important: If any Injury or once.		4 Donation 5 Other (Spec		St. A		ius Cemet			5/28/98	Leonard	town, 1	Maryland
a	apartice in the second		21. Signature of Funeral Service Lic	ensee / /	0 4	2 M	2. Name and Ad	dress	of Facility Gardine	r Funer	al Home	PA	
0	80 = 9		Michael	1-9-	Line		_			ardtown		-	
		1	23a. Part1. Entar the disaase, or co shock, or heart failure. List on	mplications that cause	d the death. Do	not en	ter the mode of	dying,	such as cardia	or respiratory a	rrest,	and 2	Approximata
	Physician		shock, or heart failure. List on	y one cause on each	line.								Interval Between Onset and Death
	/Medical		Immediate Cause (Final	Met		6.	. /		Ca			-	lan
	Examiner		disease or condition resulting in death)	a	asta			ng	Ca	acer		1	gear,
		5			Dua to (or as a	consa	quence of):					0	
	per list			b								H-FOCIE	
	rificete be executed ng physician and est the buriel-transit		Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury		Due to (or as a	consa	quence of):						
60,	be e		cause. Enter Underlying Cause (Disease or Injury	C								i	
68760	physicia s the bu		that initiated evants resulting in death) Last		Due to (or as a	conse	quence of):						
	=											i	
Box	death cer e ettendin ed for use			d									
	0 00	1	Part II. Other significant conditions	contributing to death	but not resulting	in the u	inderlying cause	given	In Part I.	23b. Dld	tobacco use c	ontributa t	to the cause of death?
P.0	ned by the deteched									10	Ves 2□ No	3 Pro	bably 4 Unknown
	es the good be de												
Records,	The law requires thet the ste has been signed by the page 2 should be deteche completed by Phys	3								24a. Was	an autopsy	24b. W	Vere autopsy findings vallable prior to
8	been should									pen	ormed?	CC	ompletion of cause
Re	The law requireste has been a page 2 should										_		
-										10	Yes 2 No	1	☐ Yes 2☐ No
Vital	Physician: The this certificate and director, pag)	25. Was case raferred to medical examiner?	(In serious)				_	6. Place of De	ath (Check only	ona)		
of	T dis	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat		utpatie		Other:		lome 5 N Res	dence 6 □O	ther (Speci	(y)
0	Ter the ners	: 1	27. Mannar of Death 1 ☑ Natural 5 ☐ Panding	28a. Date of Inj (Month, D	ury 28b.	Tima o	of 28c. I	Injury a Work?	t	28d. Describe	how injury occu	ırred	
Division	Attending or deeth. •ctor: After by the fune		2 Accident investigat						s 2 No				
N. S	r de pri de by the		3 ☐ Sulcide 6 ☐ Could not datarmine	d 289. Placa of Ir	njury - At home, f	arm, st	raat, factory, off	ice		28f. Location (City or To		nber or Rur	ral Routa Number,
Ö	tal or Attending P re effer deeth. al Director: After ted in by the funers Certification:	5	4 D Hornoda	building, e	пс. (эрвспу)					Only or 10	With Clarey		
		29a. Cartiflar (Check only (C											
	thin thin the maple								umber		20d Data al-	ad (Manth	Day Veer)
	C T W T C C C C C C C C C C C C C C C C	29b. Signature and title of certifier 29c. Licanse number 29d. Date signe								eu (Month,	Day, rear)		
			AU N	a W	3		0:	25	230		,5/2	6/80	3
		1	30. Name and address of person wh	o complated cause of	daath (Item 23a)	(Type	Print)		David C	. Allen	, MD		
		1	2050 W. (de	Lord CX	r Ca	P.	Fernin	1	nd:	2061	9		
	State		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1		_ •		-			
	Registrar		MAY 26 1	998 Julia	Ohuden K	arda	u.						



State	of Maryland /	Department	of Health ar	nd Mental	Hygiene
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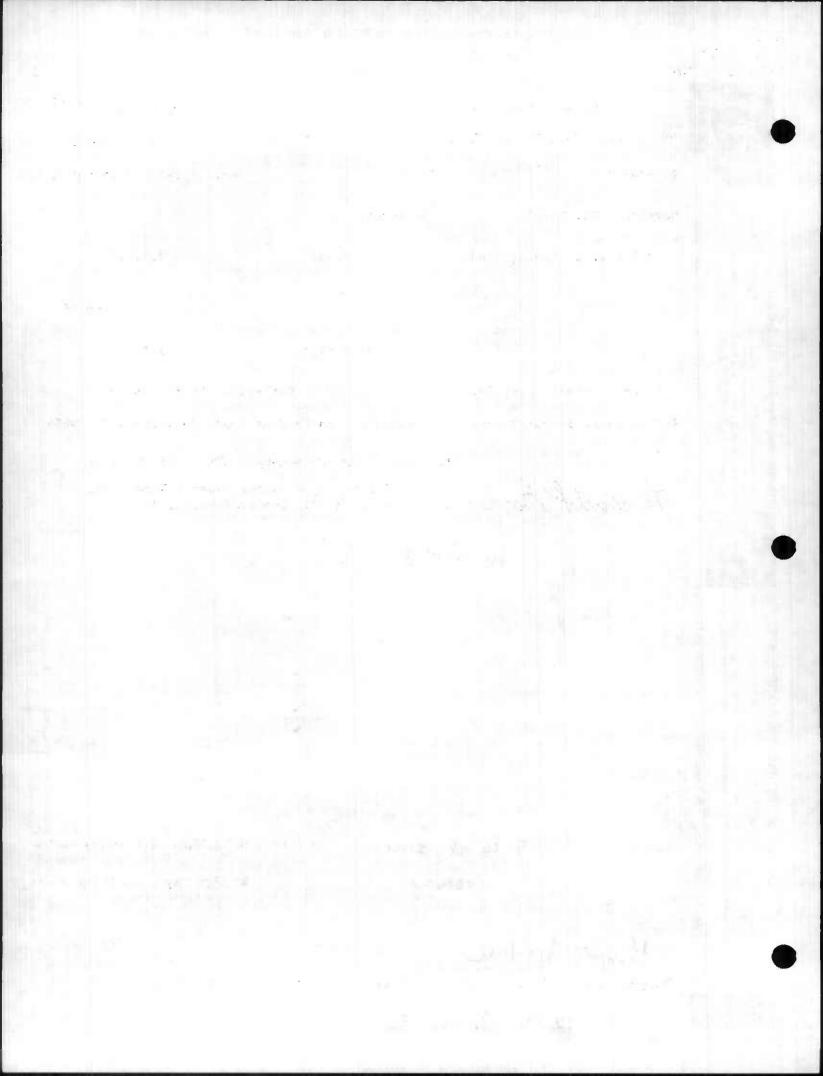
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OI IA	WIT ILLE C	_	Decedent'a Name (First, Middle, Li	est)		CE	runcai	e or L	Jealii	2.	Date of De	Reg. No.		3. Time of Death
п	Physician		Shawn		ady						Month	Day	Year	23:59 PM
	/Medica	_	la Facility Neme (If not institution, gi					4	b. City, Town		MAY on of Death	26, 19		
	Examine		PRINCE GEORGES H						CHEVE			Princ		
	Funeral	5	5. Social Security Number 6.	Sex 7.7	Age (In yrs.	last birthdey		r 1 Year	If Under 24	4 Hrs. 8.	Dete of Bir (Month, Da			place (State or Foreign intry)
п	Director		218-74-5845	1 ØM 2□ F		39 Yrs.	Months	Days	Hours	Min.	oril 8	3,1959		nington D.C.
	D.	-	Usual Residence of Decedent		10- 0									
	be filed within 72 hours after death with the Manyland tial Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at the Commission by European Discontinuous that the Medical Income.		Maryland St. Ma	ry's	10c. Cr	Holly								10d. Inside City Limits 1 ☐ Yes 2 No
	or 22	-	10e. Street and Number				10f. Zip	p Code				10g. Citizen of	What Cou	intry?
	23a	6	45265 Clarks La	nding Roa	d			2063				U.S.		
	r thems 23a		11, Marital Status	12. Was Deceder Armed Force	s?	,S. 13.	Was Dece If Yes, ape	dent of Hi city Cube	spanic Origi n, Mexican,	In? (Specify Puerto Rica	Yes or No an, etc.)	- 14. Rad Bla	ca - Amer ck, White	ican indien, , etc.
20	urs after		1 Never Married 2 Married	1 Yes 20			1 🗆 Yes	2 X No	Specify:			Specif	y:	***
21215-0020	ural ural	2	3 Widowed 4 XDivorced	Year or Dates); 	16a Daar	adantia I lau	ol Ossus	tion			16h Kind of B	uninneelle	White
15	ed within 72 ho ygiene. her than "naturi it, the Wed call		15. Decedent's E (Specify only highest gr	ade completed)		(Giv	edent's Usu e kind of wo DO NOT u	ork done o	lurina most o	of working		16b. Kind of B	usiness/ii	idustry
12	Hygiene. ther than "		Elementery/Secondery (0-12)	College (1-4o	r 5+)	1110.		o Re				Auto		
0	Hygie Hygie		17. Father's Name (First, Middle, Las	t)				T	18. Mother	's Name (Fi	irst, Middle,	Maiden Sumer	ne)	
Maryland	and Mental Hygi and Mental Hygi americal other numatic event.		Richard Henry	Cady Jr					Kat	therin	ne Pa	earl Sa	ands	
ary	2 shou and M is mark		19a. Informant's Name/Relationship		•	19b. Mei	ling Addres	s (Street				er, City or Town		ip Code)
	(1 4 7 8		Katherine P. Syd	nor/Mothe	r	452	65 C1	arks	Landi	ing Ro	oad, I	Hollywoo	od, M	ID 20636
re,	f Har item other	2	20e. Method of Disposition		20b. I	Place of Disposemetery, cre					Date	20c. Location		
E	Pages nent of int: If its iry or o		1 Ø Burial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Spec		Θ			Episcopal Cemetery 6/1/98 Oxon Hill, MD					MD	
Baltimore,	permit. Pages 1 and Department of Haalth Important: If item 27 any injury or other to once.	21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P											, P.	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,											50	Approximate
	Physician		shock, or heart failure. List only	one ceuse on each	line.								İ	Onset and Death
	/Medical		Immediate Cause (Final	a Mu	an.	F DI	1 Ain	ري					1	
	Examiner		disease or condition resulting in deeth)	a. PW									1	
_		Due to (or es a consequence of):												
	death cartificate be executed e attanding physician and ad for use as the burial-transit	8	Sequentially list conditions,	b	Due to (or as a conse	equence of)	:						
ó			Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury										1	
8760,	physician the buris	5	that initiated events resulting in death) Last	С	Due to (d	or as a conse	quenca of):	*						
9	n cartific inding p usa as													
Вох	auth cartification attending for usa a			d									1	
0.	at the death cartificate be table by the attending physicis etached for use as the burneticlery Alladical	1	Part II. Other significant conditions	contributing to death	but not res	ulting in the	underlying	cause giv	en In Part I.		23b. Dld	tobacco use co	ontribute	to the cause of death?
0	that the detached detached										1 🗆	Yes 2 No	3 Pr	obably 4 Unknown
S,	Se ngi												1 045 3	Mana autonou findinas
Record	The law requires at a has been sign page 2 should be											an autopsy ormed?	8	Were autopsy findings wellable prior to completion of cause
ec	has b												C	of death?
	The Late he	5									10	Yes 2□ No	۲	Yes 2 No
Vital	Physician: The this cartificate ral director, parent of the Co.		25. Was case referred to medical examiner?	II.				100		of Death (C	heck only	one)		
of	hys his	•	XXYes 2□ No	Hospital: 1 Inpa		ER/Outpatie			4 Nurs			dence 6 Ot		ify)
	Aftar funar	5	27. Manner of Deeth 1 ☐ Natural 5 ☐ Pending		Day Year)	28b. Time Injury		28c. Injury				how Injury occu		1. Hours
Division	tal or Attending P rs after death. al Director: After t led in by the funers	3	2 Accident investigation 5 - 26 - 98 2110 PM						Yes 2 DA					By Moron
کاز	after death after death Director: J in by the		4 ☐ Homicide determined determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)							City or To	wn, State)		ral Route Number,	
	To the Hospital or within 24 hours afte to the Funeral Dir completaly filled in Madical Carl		29a. Certifier 1 ☐ Certifying P		-0204		th nacuses	d at the ste	a data ard					cupry's cot
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	ithin of the omple		29b. Signature and title of cartifier	one manner			29	c. Licens	e number			29d. Dete sign	ed (Month	n, Day, Year)
	F 3 F 8		Man - A	2.16.00				OCM	E			MAY		1998
		-	Name and adding the	MYIM	don't /	m 02cl /*	Deleti							
		1	30. Name and address of person who	completed cause of	ueath (Itel	ii zsa) (Type	r, mint)					The second of		

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature



Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

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CASEY			Certificate	of Death	Re	g. No.	0 1	1210
Physician /Medical Examiner Funeral Director	1. Decedent's Name (First, Middle, Le	ist)			2. Date of Death	1		3. Time of Death
	Walland F. Casev			Month		Day Year 8:02 P		8:02 PM.
	4a Facility Name (If not institution, give street end number)			4b. City, Town, or I	4c. County of Death			
	SHOCK TRAUMA BALTIMORE HARFORD							
	5. Social Security Number 6. Sex, 7. Age (In yrs. lest birthdey) If Ur			rear If Under 24 Hrs.				e (State or Foraign
	219-80-5083 10M 20F 35 Yrs. Month			Pays Hours Min.	Hours Min. (Month, Dey, Year) County)			
	Usual Residence of Decedent				Dan Co	1100		
a d 21215-0020 I flied within 72 hours efter death with the Maryland of thygiene. other than "naturel", or items 23s or 28s-1 show yent, its Marical Examiner must be inclined at 38 Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit							
	MD HARFORD HAURE DE GRACE 12 Yes 2 No							
	10e. Street and Number ,			f. Zlp Coda 1			Vhat Country	?
3a o	393 W1/50N 5+			21078		USA		
ms 2	11. Maritai Status	12. Was Decedent Ever in U,S. 13. Was D		t of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-		4. Rece - American Indian, Black, White, etc.	
Fur free Fur	1 Never Married 2 Married	Armed Forces?	/					
DZC Urs e	3 □ Widowed 4 □ Divorced	Year or Dates: 1987		Yes 20 No Specify:		Specify: BIACK		
21215-0020 d within 72 hours efter print han "naturel", or te tre Marical Examina completed by Fu	15. Decedant's Education 16a. Deced			cedant's Usual Occupation			islness/Indus	itry
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d 21215-0 flied within 72 ho Hygiene "nature and, the Maximal	Elamentary/secondary (0-12)	College (1-401 34)	CONSTONE	HOUSING				
be filed tel hyging dother event, the Co	17. Father's Name (First, Middle, Last		18. Mother's Name (First, Middle, Ma			faidan Sumame)		
Maryland d 2 should be file th end Mentel Hy 7 is merked oth traumetic event	WAllace Casey			Louise Hubbard				
aryla should end Men end Men aumetic				ddress (Street end Numbar or Fjurel Royte Number, City or Jown, State, Zip Coda)				
Baltimore, Maryland 21215-6 permit. Pages 1 end 2 should be filled within 72 ho Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "naturany or other traumatic event, it a Marical and any injury or other traumatic event, it a Marical and any injury or other traumatic and any injury or other traumatic event, it a Marical and any injury or other traumatic event, it a Marical and any injury or other traumatic event.	WAllace Casex 393 L			Wilson St HAVNE de Grace, MP				
	20a. Method of Disposition	20a Method of Disposition 20b. Place of Disposition (Neme of Data 20c. Location - City or Town, State						
	1 Burlal 2 Cremation 3 Removal from State Carrison Forest Cem 5-21-98 Owing 5 Mill, MD							
	BEARN Funeral Nome							
	23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximate							
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that causad tha death. Do not enter the mode of dylng, such as cardlac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death							
	Immediata Cause (Final disease or condition resulting in death) Stat wounds, multiput Due to (or as a consequence of):							
								ox 68760, certificate be executed ding physician and use as the bunal-transit
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):							
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6876C	that initiated events						- 1	
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ecords, P.O. w requires that the d s been signed by the 2 should be deteched	Part II. Other significant conditions contributing to death but not resulting in the underly			ring cause givan in Part I. 231		3b. Did tobacco use contributa to the cause of death?		
					1 🗆 Yı	18 2 NO	3 Probat	bly 4 Unknown
					Ode Wee a	- autonou	24h Were	autopsy findings
					performed? available pr		abla prior to bletion of cause	
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The la					1 ₩ Ye	s 2 No	100	res 2□ No
Vital I		26. Place of Death (Check only one)						
- X 50 C		Hospital: 1 ☐ Inpatient ②□ Inpatient 3 ☐ DOA Other: 4 ☐ Nursing I			Home 5 ☐ Residenca 6 ☐ Other (Specify)			
g Physics neeral d		28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?			28d. Describe how injury occurred			
Attending or death. Ctor: After by the lune liftcation				1 ☐ Yes 2 No	Suljecto stables			
Division of low Attending Parties of the death. I Director: After the in by the luners.	3 Suicide 6 Could not to datarmined	De Place of injury. At home form street factors		office	28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 200 Cedan Orius			
Division of the division of th				Balting		ne City, MD		
Division o To the Hospital or Attending Ph within 24 hours efter death. To the Funetel Director: After th completely filled in by the funeral Medical Certification:								
ne Hospi n 24 hou ne Funer pletely fil	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and due to the cause(s) and manner stated.							
To the Hospital of within 24 hours of To the Funeral completely filled	29b. Signatura and titla of certifier			29c. License number		29d. Date signed (Month, Day, Year)		
/	Donald & Wright MD			O.C.M.E.		MAY 22, 1998		

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Downed G. Wright MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Den Ygar) 1998

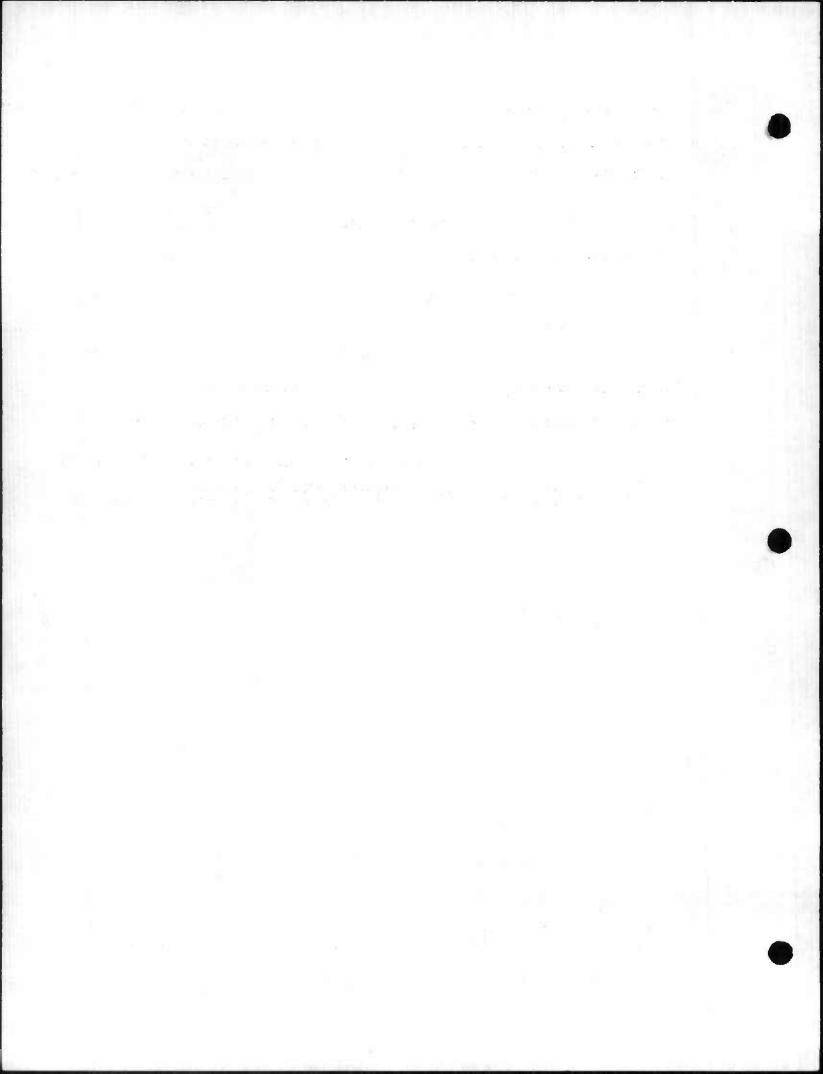
Registrar

Liberty to prove the state of Soph warmer and Copies

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

			State of Maryland / Department Certifica				Reg. No.		1211
	Physici /Medi		Decedent's Name (First, Middle, Last) Thomas James Connelly			2. Date of De Month 05	Day	Year 98	3. Time of Death 14=20 HF
	Funeral Director		4a. Facility Nama (If not institution, give street and number) 100 Revolution St. Apt 505 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 1f Under Months 215-30-6337 X M 2 F 65 Yrs. Usual Residence of Decedent	Haver 1	City, Town, or Lo Vre de Undar 24 Hrs. Hours Min.		Harfo	9. Birthp	lace (State or Foreign try) lington DC
	the Marylend 28a-f show notified at	Director	10s. State 10b. County 10c. City, Town or Location MD Harford Havre de Gr	Cace			10g. Citizen of W		Od. Inside City Limits 1 Yes 2 No
0020	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylend Department of Heelth and Mental Phyliene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	100 Revolution Street Apt 505 11. Marital Status 1 Nevar Married 2 Married 3 Wildowed 4 Optivorced 1. Nevar Married 2 Married 1. Street Apt 505 1. Nevar Married 2 Married 1. Street Apt 505 1. Street Apt 505 1. Was Decedent Ever in U.S. Armed Forces? 1. Street Apt 505 1. Was Decedent Ever in U.S. Armed Forces? 1. Street Apt 505 1. Was Decedent Ever in U.S. Armed Forces? 1. Street Apt 505 1. Was Decedent Ever in U.S. Armed Forces? 1. Street Apt 505 1. Was Decedent Ever in U.S. Armed Forces? 1. Street Apt 505 1. Was Decedent Ever in U.S. Armed Forces? 1. Street Apt 505 1. Was Decedent Ever in U.S. Armed Forces? 1. Street Apt 505 1. Was Decedent Ever in U.S. Armed Forces? 1. Street Apt 505	078 edant of Hispa ecity Cuban, N	anic Origin? (Spo Maxican, Puarto Specify:	ecify Yas or No Rican, etc.)	USA 14. Race Blace		an Indian, etc.
Maryland 21215-0020	filed within 72 h Hygiene. ther then "netuent, the Medica	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12 17. Father's Name (First, Middle, Last)	ork done durin use retired) Drer	ng most of work		Constr	uctio	
farylan	2 should be f and Mental b is marked of raumatic eve	To Be	Patrick James Connelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	٨	Mildred	Wyre			Code)
altimore, N	Pages 1 end tment of Heelth tant: If item 27 jury or other tr		Thornas J Connelly, Jr- Son 8 Colora 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Donetion 5 Other (Specify) R.A. Ferris	eme of other place)	Inc. 5	Colora, Data /27/98	20c. Location -		
Bal	permit. Departr Imports eny inji		Mitche	Washi	h Fune	St. Hav	ne, P.A.	iraçe	
	Physician /Medical Examiner		shock, or heart failura. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) Due to (or as a consequence of)		uch as cardiac (or respiratory a	rrest,		Approximate Interval Between Onset and Death
°,	ficate be executed physician and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury c						
Box 68760,	deeth certificate be executed e attending physiclan and of for use es the burial-transit	an/Medicai	that initiated events resulting in death) Last Due to (or as a consequence of)	:					
P.O.	es that the deet igned by the att be deteched for	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying Hypertension	cause given in	n Part I.			tributs to	the cause of death?
Records	ew requires been s	Completed b					an autopsy rmed?	ava	ere autopsy findings allable prior to mpletion of cause death?
Vital		Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 inpatient 2 ER/Outpatient 3 D	Othor	3. Place of Deeth	Check only o			Yes 2 MNo
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Certification: To	27. Magner of Death 1 ② Naturel 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 28a. Date of Injury (Month, Day Year) NA 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	28c. Injury at Work? 1 ☐ Yes	2 💢 No	28d. Describe	dence 6 □Other now injury occurre NA Street and Number on, State)	ed	
۵	To the Hospital or within 24 hours eff To the Funeral Di completely filled in	edical Cer	29a. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.	l et the time, c	date and place, a	and due to the	N A	nner as at	ated. the cause(s)
	To the within To the comp	Me	29b. Signaffere and title of certifier DME	OCME	ımber		29d. Date signed		
			30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) G.S.Prabhu M.D.218 Fulford Ave Bell 31. Date filed (Month, Day, Year)	Air	MD 210	014 4	10-879-	-656	4
F	Sta Registr		31. Date filed (Month, Day, Year) 32. Redetrar sisjonature						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene \(\text{Q} \)

						,		Certific	ate of	Death		Reg	. No.	1	() () () () () () () () () ()
		_	1. Decedeni's Name	a (First, Middle, L	ast)							te of Death		Vans	3. Time of Death
П	Physicia /Medica		OLGA L	AURIE CL	AYTON						NIC	onth	Day (Year Y	3:27 An
4	Examine		4a Facility Name (I	f not institution, g	iva street and num	ber)				4b. City, Town,	or Location	of Death	4c. County	of Death	
4			Glen Mea	adows He	alth Car	e Cen	ter			Glen A				imore	2
	Funeral Director		5. Social Security N 216-46-6		Sax 1□M 2☐F	7. Age (In y		hday) If Un Monii	der 1 Yaa ns Days		Ain. (M	te of Birth onth, Day, Y	^{ear)} 1905	9. Birthpl Count Dela	aca (Stata or Foreign lry) Ware
	2	- 1	Usual Residence of			10-	0h. T	or Location						T a	Od Jacobs Obstimite
	ith with the Marylan 23e or 28e-f show	34	10a. Stale	10b. County										10	od. Inside City Limits 1 ☐ Yes 2 ☐ No
	M er	2 -	Maryland	Baltir	more		Glen .	1				140	(M)	10-11-0	
	dith the	2	10e. Street and Nur		Dood.			101.	Zip Code			100		f What Country?	
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	ter das	Funeral	11. Marital Status		12. Was Deced	ces?	U,S.	13. Was De	pecify Cu	Hispanic Orlgin's ban, Mexican, P	(Specify Your arto Rican,	es or No- etc.)		e - Amaric k, White,	
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5-0	72 h	Completed	(Spec	15. Decedent's l			16a.	Decedent'a U (Giva kind of	work don	upalion e during most of red)	working	16	b. Kind of Bu	of Business/Industry	
121	within ena. than	ğ	Elementary/Seco		College (1-	4or 5+)				red)					
			49 E.W. 10 March	Fina Adidata Ana	3		HC	memake	r	18. Mother's	Name (First		Own Ho		
Supple	d ta by	Ď	17. Father's Name (M.	Smith		10)	
7	Me Me	2	-						10.					O	0-4-1
Maryland	O1 00 00 00		19a. Informant's Na	me/Ralationship Clayton						et and Number o					
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Baltimore,	Peges nent of It ant: If ite ury or of		20e. Method of Disp 1 Burial 2		Ramoval from S	tate	cameter	y, crematory	or other p	•			C. LOCATION	Oily Oil 10	wii, Stata
tim	nit. Pe vartmen ortant: Injury			5 Other (Spec	•	H	illto	p Serv			5-19	-98 7	lowson	, Mar	yland
Sal	permit. P Departme importan any Injur		21. Signature of Fu	11 1	201	1		Hor.m	V For	ress of Facility McComa	e TTT	Funer	cal Ho	mo E	7
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п			23a. Part1. Enter the shock, or hear	disease, or contract failure. List only	mplications that ca y one cause on ga	used the dich line.	eath. Do r	not enter the r	node of d	ying, such as car	diac or resp	iratory erres	τ,		Approximete Interval Batween
1	Physician				•									i	Onset and Death
	/Medical Examiner		Immediate Cause (disease or condition		. 01	100	rom	ria							6 days
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	rificate be executed ng physician end as the bunal-transit	Examiner	Sequentially list con	nditions,	U.	Due to	o (or as a o	consequence	of):						
68760,	sian cian		Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	rlyIng	C										
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Box	eath cert ettendin I for usa	200			J									1	
	iaw requiras that the death cen as been signed by the ettendir s 2 should be detached for usa	Physician/M	Part II. Other signif									3b. Did tob	ecco usa co	ntribute to	the cause of death?
P.0	that the dended by the ended end	5	Severe	oste	o poru	sis	W	ith	res	triction	ne	1 🗌 Yee	2 2 No	3 Pro	bably 4 Unknow
Records,	ras ti signe	2		1	o porodisens							4n Manan		24h W	ere autopsy findings
0	v require	Completed		ung	0 (54 19)	5					2	4a. Was an		av	allable prior to
ec	law las b	d													death?
	The law cata has page 2	0										1 🗆 Yes	2□No	10	Yes 2□ No
Vital	E # 0	e C	25. Was case reference examiner?	red to medical	10 - 20 -	70					Death (Che	ck only one)			
of	hysic his ce	0	1 Yes 2 X			patient 2			DOA			5 Residen			y)
	une une		27. Manner of Deatl 1 ☑Natural 2 ☐ Accident	h 5 Pending Investigati		f Injury n, <i>Day Year</i>		Time of njury M	28c. In W	juryat /ork? □ Yes 2 □ No	28d. C	escribe how	injury occur	red	
Division	after death. Director: A	27. Manner of Death 1 Natural 2 Nacident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 4 North? 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28e. Placa of Injury - At homa, farm, straal, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
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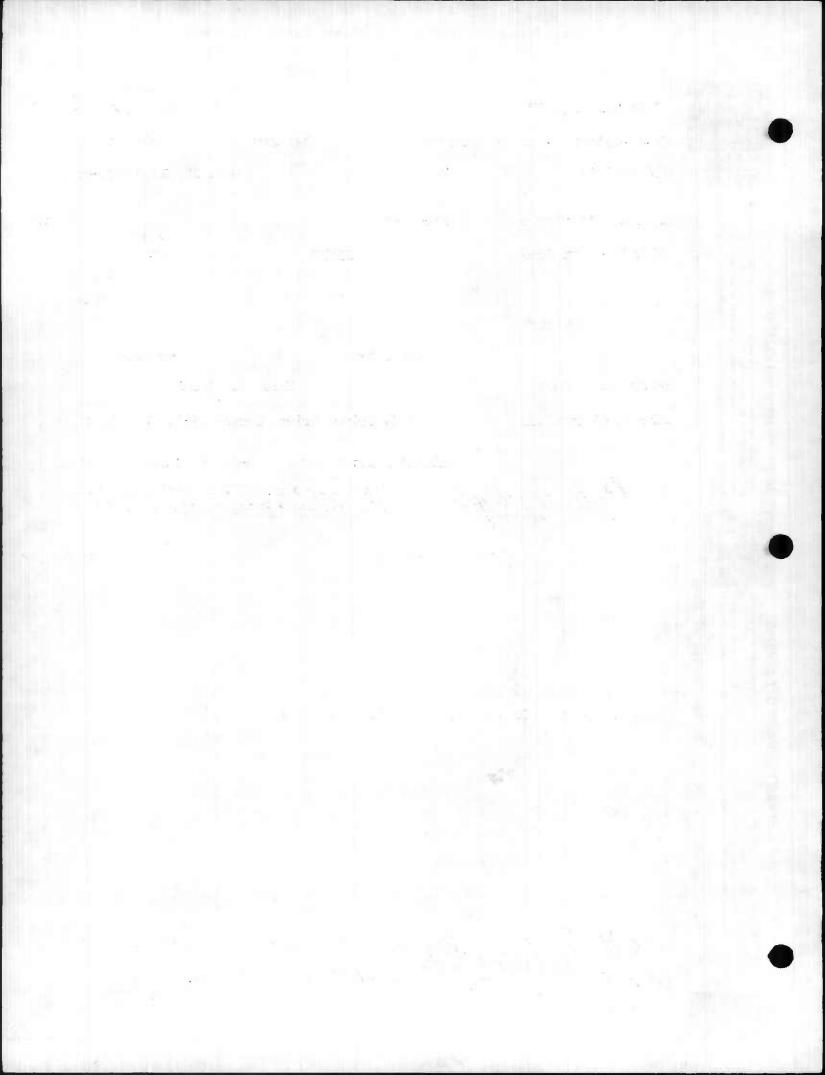
15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State

29a. Certifier (Check only one)

Registrar



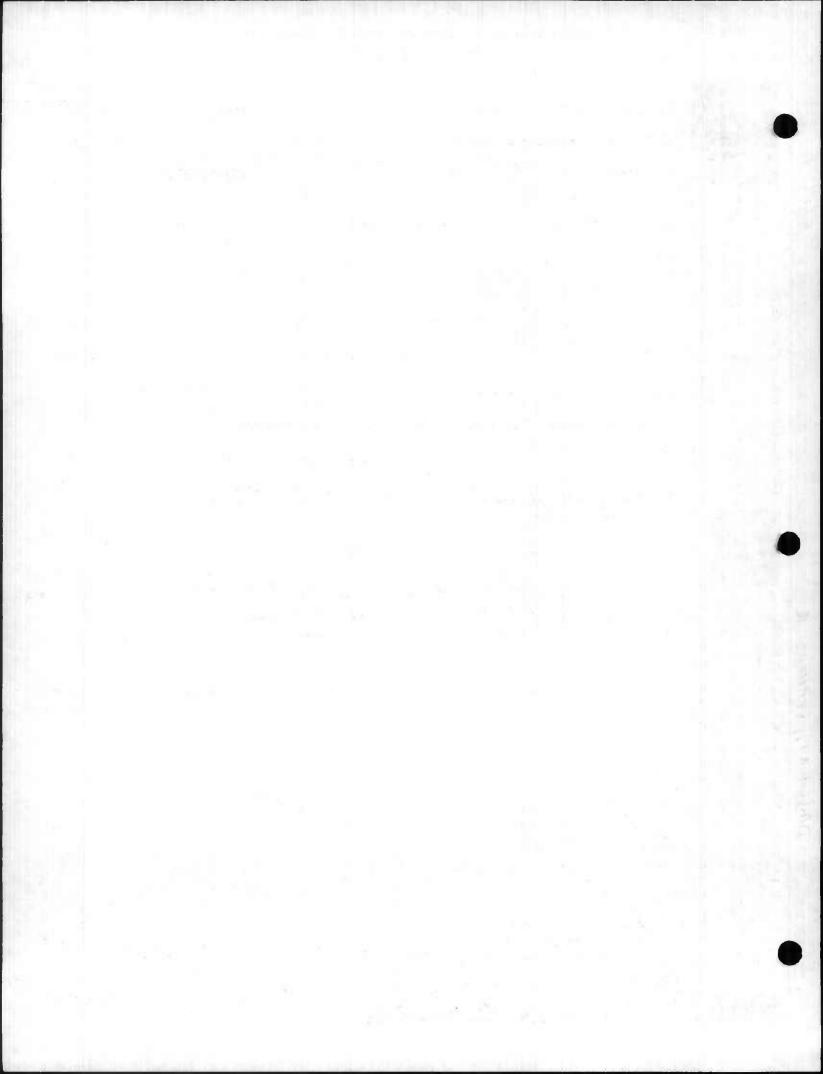
State of Maryland / Department of Health and Mental Hygiene

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					Cei	tificate	of Dea	th		Reg. No.	20	1/6/0
1.10.1	1. Dece	dent's Nama (First, Mi	ddle, Last)						2. Date of De	ath		3. Tirh f th
Physician	Fr	ances Rom	aine Dau	igherty					Month	Day	Yaar Q	Am
/Medical Examiner		ity Nama (If not Institu					4b. City.	Town, or L	ocation of Death	4c, County	of Death	200
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		Security Number	6. Sax			If Undar 1	0.300	dar 24 Hrs.				-
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nooved at		100.000	inty	106. Cr	y, rown or Lo	cation					10	d. Insida City Limits
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Director	10e. Str	et and Number				10f. Zip Co	oda			10g. Citizan of	What Counti	ry?
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To		erman Sch	olar McC	lavin			C	vrena	Kather	ine Lov	10	
1		ormant's Name/Ralatio			10h Maitin	n Addrage /6		•		er, City or Town,		Codel
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8	23a. Pe	rt1. Entar the diseese, ock, or haart failure. L	or complications ist only one cause	that caused the deat	h. Do not ante	ar the moda o	f dying, such	as cardiac	or raspiratory ar	rast,		Approximate Interval Between
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ner	rasulting	or condition in death)	a. /			_	98.					
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Examiner	esame.		- 500	VINCOS	100	2049	9 06	14/2	asher.	_	1	4.05
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	Cause /	Disease or Injury	1 1/	20000	1 200	401	10		-		10	/
edical	that inti-	sted events in death) Last)	Due to (o	as consequ	ence of):	_				1	
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Physic	Part II. O	ther significant cond	itions contributing	to death but not res	uiting in the un	derlying caus	e given in Pa	ert I.	23b. Did 1	opecco use co	ntribute to t	the cause of death?
Physician									110	Yes 2 No	3 Probe	ably 4☐ Unknow
by	-											
eted										an autopsy	24b. Wer	e autopsy findings lable prior to
9									peno	rmed?	/ opm	pletion of cause
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0	10	1.0	Hospital:	1 Inpatient 2 I	ER/Outpatien	3E DOA	Other: 4th	Nursing Ho	me 5 Resid	tence 6 🗆 Om	er (Specify)	
	27. Mann	of Death		Date of Injury	28b. Time of	280.	Injury at Work?	the same of the sa		now injury occur	-	
Certification:	1 (0)	Vatural 5 ☐ Pen Accident inve	ding stigation	(Month, Day Year)	Injury	M	Work7 1 ☐ Yes 2	DNo				
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ŧ	40	Homicide dete	rmined 28e.	Place of Injury - At he building, etc. (Specif	y)	ret, factory, o	IIICB		City or Tow		en or Himan	House reunicer,
		/										
edical	29a. Car	tifier 1 Certif	ying Physician: T	o the best of my kno	wledge, death	occurred at t	he time, date	and place.	and due to the	cause(s) and ma	nner as sta	ted.
Pe	an		and	he basis of examina manner stated.	non arrovor my	osugition, in	my upinion, c	Jeans Godun	rest at the time, i	uete and place,	and due to t	ne cause(s)
ž	29b. Sig	natura and title of certi	finer La	/_		29c. L	icense numb	or		29d. Date signe	d (Month, D	ay, Year)
	b	1 0000	1			11/	117	2	2	la des a	11	1098
1	1	0196	01	(20 10	D	1/15	100)	1.	190	1, 1	17/0
	30 Nam	and address of person	on who completed	cause of death (Item	23a) (Type	Print)		1	. 11		10	_
	1/A	14 (1)	FIM	, PT.D	301	1.1	2104	DUG	s. H	gyre	de	12060
-		flied (Month, Day, Yes		32. Registrar's Signe	tura	-	W1		20.00		21	008
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State istrar	31. Date	MAY	2 2 1998	Mali: As.	clear Re	10						10

DAUGHERTY, FRANCES



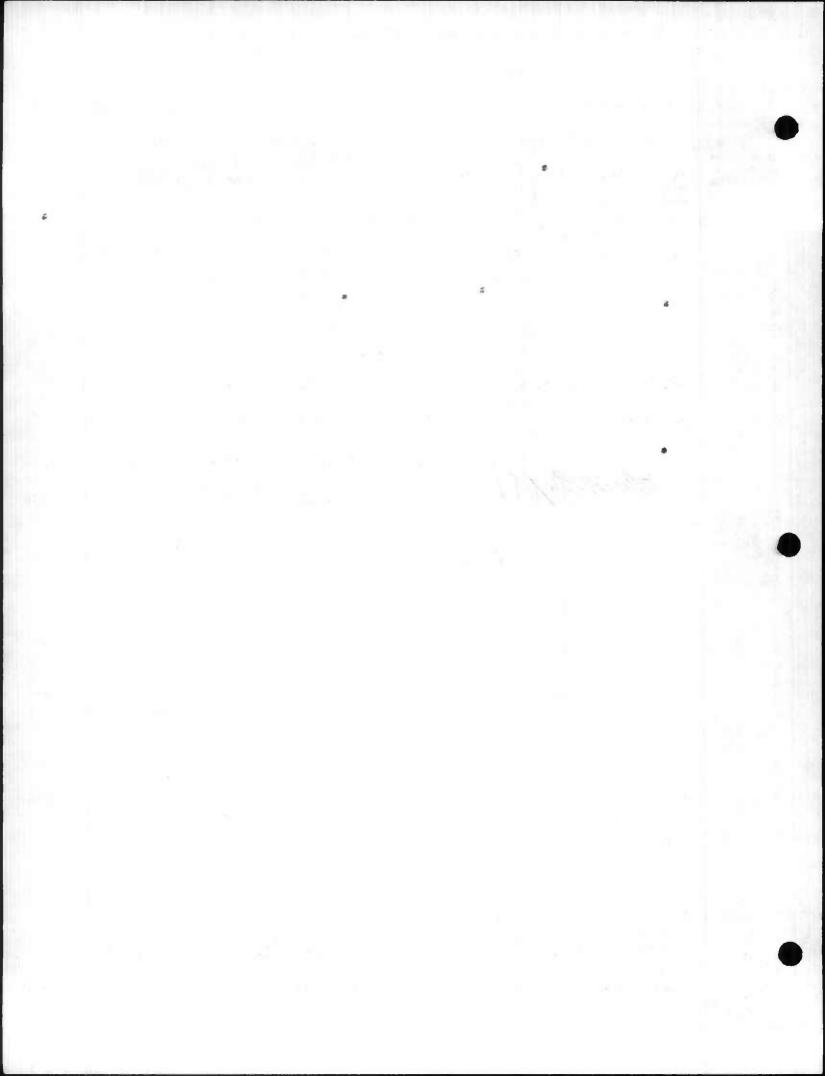
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** May 23, John William Ellis, Jr. 11:47 AM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 39430 Sunnyside Road Clements St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days Hours 1 ■ M 2 □ F Director 214-28-7561 66 Yrs. September 2, 1931 Maryland Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2 III No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 1112, Lawrence Avenue 20650 United States Herns 23a death Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, permit. Pages 1 end 2 should be filled within 72 hours after of Department of Health end Mental Hygiene. If item 27 ie marked other than "natural", or Hei Important: If item 27 ie marked other than "natural", or Hei Black. White, etc. 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ■ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John William Ellis, Sr. Edna Mae Jones 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Paul Howe 39430 Sunnyside Road, Clements, Maryland 20624 other 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Buriai 2 Cremation 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart Cemetery 5/26/98 Bushwood, Maryland 22. Name end Address of Fecility Brinsfield, Brinsfield Funeral Home, P.A. Edward N. Jr. M00052 22955 Hollywood ROad, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such es cardiec or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Interval Betw **Physician** /Medical Immediate Ceuse (Final 14 mos. disease or condition resulting in deeth) Examiner e to (or es a consequenca of): Physician/Medical Examiner attending physician and for use es the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to Immediete cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting In death) Lest Due to (or as e consequenca of): Box 68760. Due to (or as a consequence of): P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director, Be 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4□ Nursing Home 5★ Residence 6 □ Other (Specify) Certification: To 1 ☐ Yes 2 No this the funeral 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? After 1 Naturel 2 Accident 5 Pending 1 Yes 2 No death. Investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 1 Cartifying Phyalclan: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier Medical completely (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OBUNHED & D50686 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Gurdeep C
31. Dete filed (Month, Dey, Yeer) ST. MARY'S HOSPITAL LEONARDTOWN, YNd 20650 Chhabre no 32. Registrer's Signature State Jalia Davidson Randall

DHMH 16 Bay 6/95

Registrar

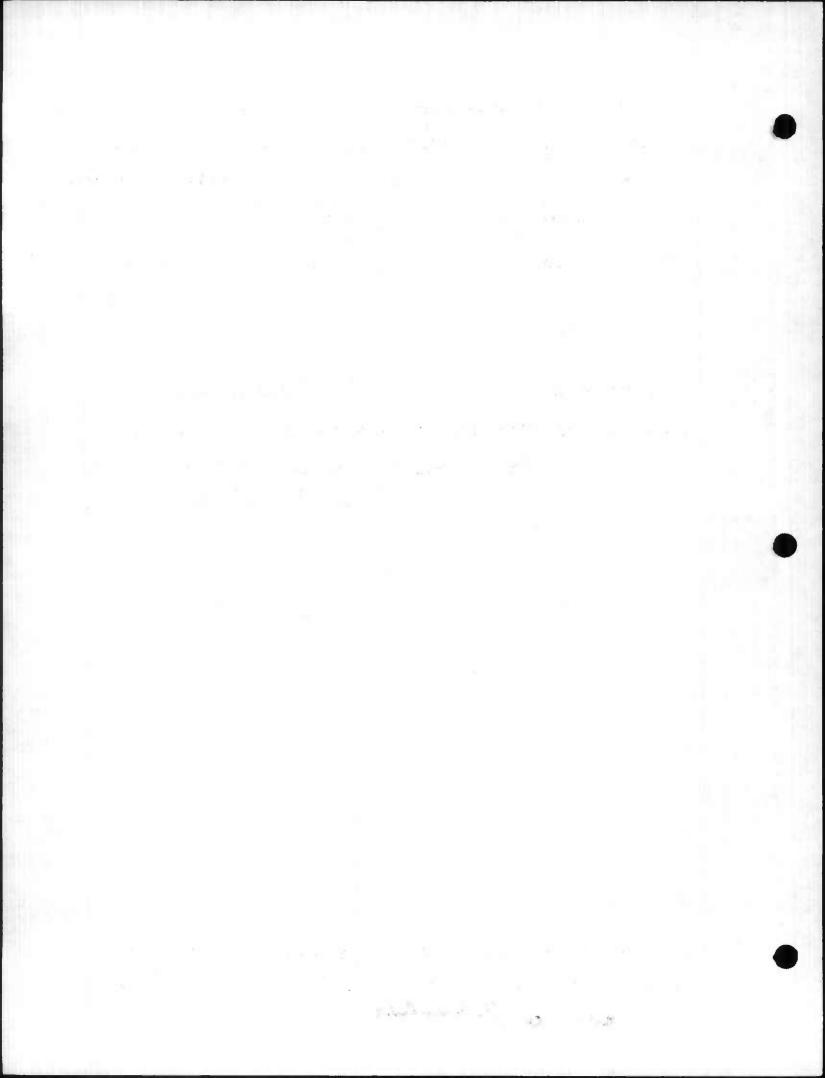
MAY 28 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma		Certificate of			gierie	8	7275			
			1. Decedent's Name (First, Middla, I	Last)				2. Date of Dea	ith		3. Time of Death			
	Physici /Medio		Elizabeth	Schindele	Gueri	n		Month May	18, 1998	Yaar }	7:45pm			
	Examir		4a. Facility Nama (If not institution, g	A THE RESERVE THE PERSON NAMED IN COLUMN 1			4b. City, Town, or Loc	ation of Death	4c. County	of Death				
		Н	Fairhaven L				Sykesvil		Carr					
	Funeral Director		5. Social Security Number 6. 214–40–4559 Usual Residence of Decedent	4 DM OFF	a (In yrs. last birt	thday) If Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birt (Month, Da) Aug 10	h, Year)		ea (State or Foreign and			
	dend wo		10a. State 10b. County		10c. City, Town	or Location				10d.	. Inside City Limits			
	Men.	to	MD Carro	11		Sykesville	е				Yes 2 No			
	h the	Director	10e. Street and Number	-		10f. Zip Code			10g. Citizen of V	Vhat Country	7			
	th will		7200 Third Avenu	ue .			21784		II S	Δ				
	en r	Funeral	11. Marital Status	12. Was Decedant I Armed Forces?	Evar In U,S.	13. Was Decedent of I		cify Yes or No-	14. Raci	A e - Amarican k, White, etc	Indian,			
Maryland 21215-0020	n 72 hours after death with the Meryland "natural", or items 23a or 28a-f show exical Expending must be notified at	by	1 ☐ Never Married 2 ☐ Married ②☐ Widowed 4 ☐ Divorced		40	1□ Yes 2√□ No			Specify					
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121	filed within 72 ho Hygiene. other than "naturent, I've Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		nd)							
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ary	S D E E	-	19a. Informant'a Name/Relationship		19b.	Meiling Address (Street				State, Zip Code)				
	1 and 2 Health e em 27 le		Mr. Charles Bowye	er (Attorne	v) 60	00 Washingto	on Ave. T	ดพรดท	MD 2120	14				
ore,	of Hear		Mr. Charles Bowyer (Attorney) 600 Washington Ave., Towson, MD 21204 20a. Method of Disposition Date Communication 20b. Place of Disposition (Name of cemetary, crematory or other place) Communication 20c. Location - City 20c. Location - Ci											
im	Pages nent of P ant: If Ite ury or of		4 □ Donation 5 ☒ Other (Spec	Cify) Entombre			1	20/98	Baltimo	re. M)			
Baltimore,	permit. Peges Department of Important: If It any Injury or o		21. Signature of Funeral Service Lic	ensee	11	22. Nama and Addre	ass of Facility							
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	Physician		23a. Part1. Entar tha disease, or co shock, or heart failura. List on	mplications that caused ly one cause on each lin	the death. Do n	ot entar the mode of dyl	ng, such as cardiac o	raspiratory ar	rest,	A In	pproximate hterval Between hisat and Death			
E	/Medical Examiner		Immediate Causa (Final disease or condition	adva	unad	demen	hia			m	onths			
h	Examine	<u></u>	resulting In death)	a	Due to (or as a c	consequence of):				1				
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	E 016		resulting in death) Last		Dua to (or as a c	onsequence of).								
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islo	Attending or death. ector: After by the fune	lcat	2 Accident investigati 3 Suicide 6 Could not	ba con Dinas et lais	Inv. At home fee	rm, street, factory, office		Rf Location (5	Street and Numb	er or Rural R	loute Number			
Division	after Direct	erti	4 Homicide determine	building, etc		in, street, ractory, onice		City or Tow		or or ridiarri	oute realizon,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and due to the cause(s) and manner.									ed. na cause(s)			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and manny de		29c. Licen	se number		29d. Date signe	d (Month, Da	iy, Year)			
	->		Pin	C. M	1 MO	D 2	4406		May	9.19	998			
			30. Name and address of person who	o completed cause of de	eath (Item 23e) (Type, Print)				- 1 - 1	, ,			
			Richmond P.			Liberty R	d. Elde	-560	75, M	10 2	1784			
	Sta Registr	-1	31. Date filed (Month, Dey, Year) MAY 2 0	32. Pégistra	aris Signature	artall								

DHMH 16 Ray 6/95



Ammended Harford County Health Dept. Line # 4 thru 8 & 16a KDG 5/26 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth Month **Physician** 1105 pm MAY JENNIE M. GROVE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street end number) Examiner HArford Belcamp Lorien Nursing and Rehab Center If Under 1 Year 7. Age (In yrs. lest birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Delta PA 5. Sociel Security Number **Funeral** 1□M 2□X Months Deys Min Yrs 212-13-1665 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other trsumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2K No Director MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21154 United States Funeral 3624 Scarboro Road Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mentei Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Martine 2006. 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Disabled Unk. None 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) To Be Joseph M. Grove Amelia Chandlee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Christopher Tome/Nephew 3927 Pulaski Highway, Abingdon, MD 21009 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete Olivet Cemetery 5/22 Mt. Fawn Grove, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Harkins Funeral Home, Inc., Delta, Part 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of) Part II. Other algorithment conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably → Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Tursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Dey Year) 28h. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and menner stated. 29a. Certifie edical completely (Check only one)

requires that the death certificate be executed P.O. Box 68760 Division of Vital Records.

ettending physician and for use as the burial-transit signed by After this cartificata has or Attending Physician: funeral death. aftar death

28a-f show

FNNY M. Grove

To the Hospital within 24 hours a To the Funeral C Hospital

> State Registrar

29b. Signature

30. Name end eddress of purpor who completed cause of death (Item 23a) (Type, Pript) 101

29d. Dete signed (Month, Dey, Year)

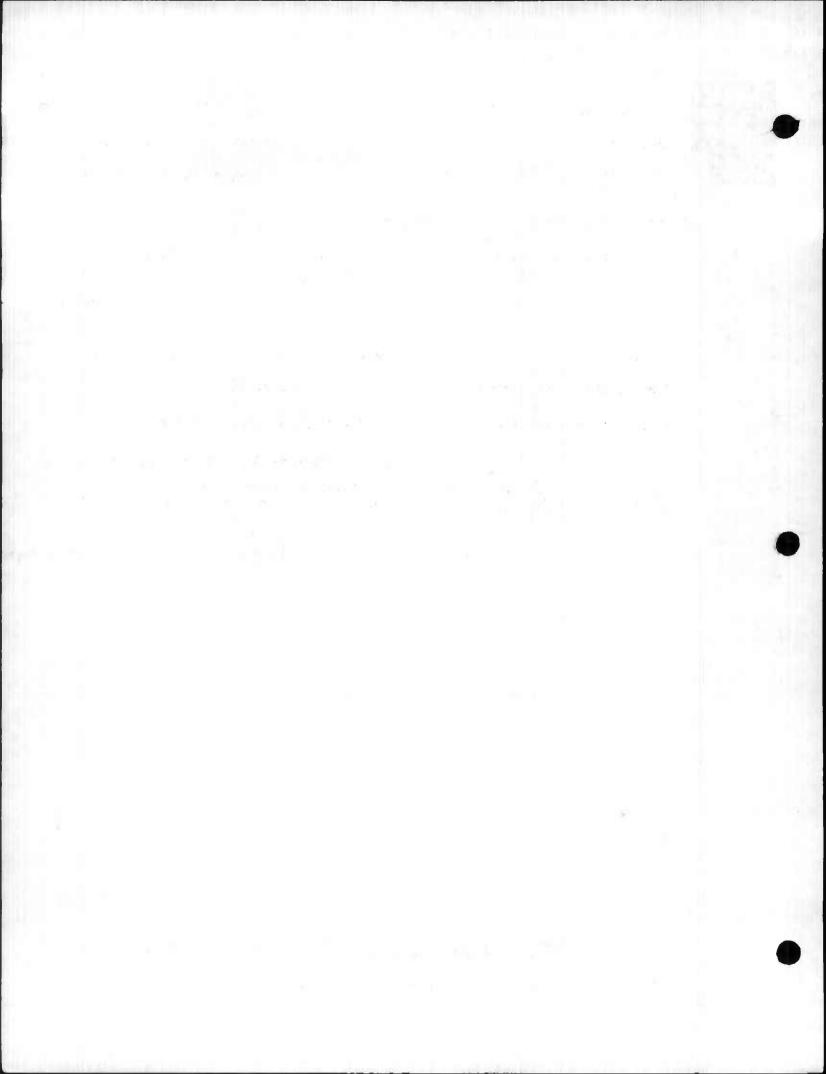
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 23^{Dey} **Physician** MAY 1998 1:20 AM Maude Elizabeth Hill /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner St. Mary's St. Mary's Hospital Leonardtown 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 201F Months Days Hours Min Yrs. Director 80 August 20, 1917 Maryland 579-22-5658 Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location tr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20650 U.S.A. 22333 St. Clements Avenue death Funerai 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. filed within 72 hours effer. Hygiene. 1 ☐ Yes 2 If Yes, Give 2 X No 1 ☐ Never Married 2 ☐ Married 10. Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 → Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Credit Union 10 th Manager permit. Pages 1 and 2 should be filed Department of Health end Mental Hygic Important: If Item 27 is marked other 1 any Injury or other treumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Eva M. Hill John Marshall Huntington 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 98 Loveville, MD 20656 Lorraine B. Hancock/Niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Charles Memorial Gardens 5/26/98 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecilit Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 line ardener Enter the disease, or cont or heart failure. List only complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** tmmediate Ceuse (Final disease or condition resulting in death) /Medical acci dent Cerebro-vascular about 10 days Examiner Due to (or es e consequence of) Examiner certificete be executed use as the buriel-transit Sequentietly tist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in death) Last Pue Due to (or es e consequence of) P.O. Box 68760. nding physician Physician/Medical Due to (or as a consequence of) Por Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 ☐ Probably 4 🖾 Unknown Records, by 8 24b. Were eutopsy findings evailable prior to Completed 24e. Was an autopsy parformed' completion of cause of deeth? The law pege 2 certificate hes 1 ☐ Yes 2 1 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 thpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28e. Date of Injury (Month, Dey Yeer) 28c. Injury et Work? To the Hospital or Attending PI within 24 hours effer deeth.
To the Funeral Director: After the completely filled in by the funera 28b. Time of 28d. Describe how injury occurred After t 1 Neturat 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide 1 Cartifying Phyalcien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the ceuse(s) and manner steted. Medicai 29a. Certifier (Check only one) 29b. Signeture end title of certifier-29c. License number 29d. Date signed (Month, Dey, Year) 26, May 98 D50044 Dr. M. A. Rahman, MD 30. Name end address of parson who completed cause of death (ttem 23a) (Type, Print) Hollywood, Maryland 20636 M. A. Rahman, MD 31. Date filed (Month, Day, Y 32. Behistrary Signature State 26 1998

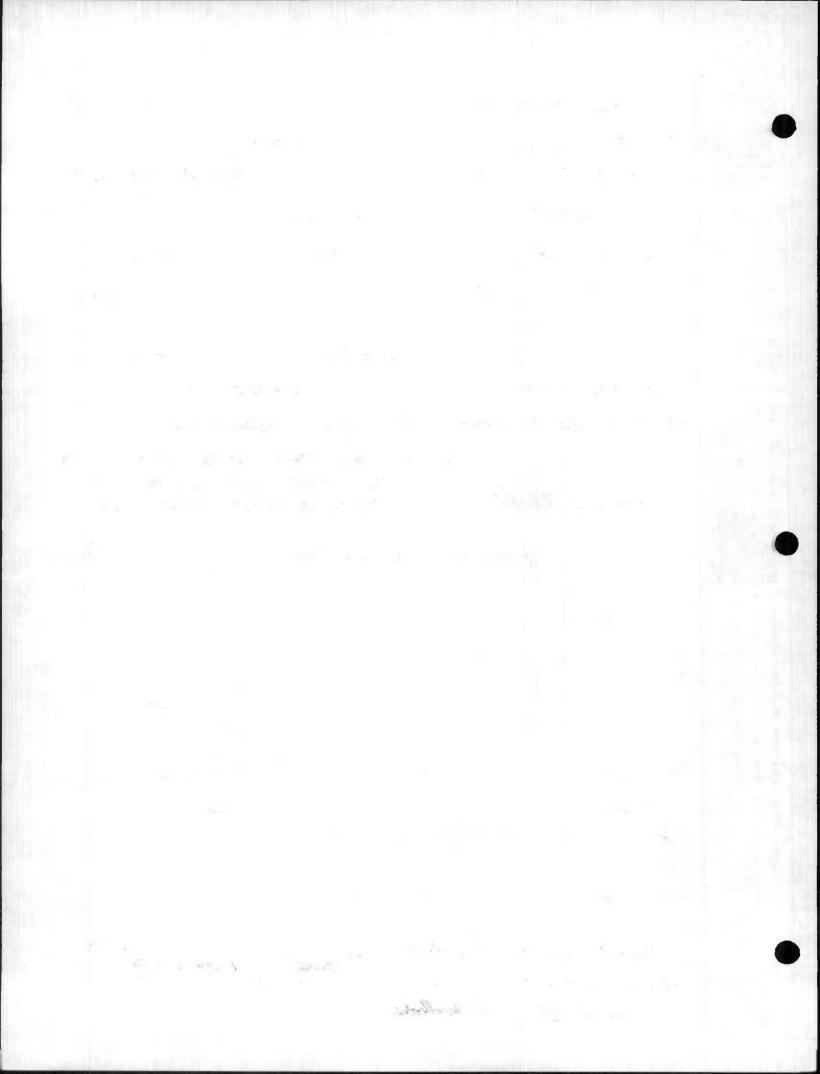
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

- 11						Certifica	te of	Death	Re	ng. No.	8	17:	278	
	Dhysis		1. Decadent's Nama (First, Middla, La						2. Date of Death		Vaar	3. Tir	ma of Death	
	Physici /Medi		Carrie Fra	ances Hawk					May 17	7, Day 998	Yaar	9:	10pm	
0	Examir		4a. Facility Nama (If not institution, given	ra street end number)				4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth			
			1612 Liberty Roa	ad				Sykesvil		Carr	oll			
	Funeral Director		5. Sociel Security Numbar 6. S 216-80-7222 Usual Rasidanca of Decedent	6ex 1□ M 2□XF 30	(In yrs. last bin	Yrs. If Unde Months	Days		8. Data of Birth (Month, Day, March 2	^{Year)} 29, 195	Cause	20013	nd	
	land w m		10a. Stata 10b. County		10c. City, Town	or Location					1	0d. Insk	da City Limits	
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21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mod cell Examinet must be notified at once.	by Funeral Director	11. Marital Status 1 □ Navar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decadant E Armed Forcas? 1 ☐ Yes 2 ☑ N If Yes, Giva Yaar or Datas:				Hispanlc Origin? (Sp pan, Mexican, Puarto Specify:	ecify Yes or No- Rican, atc.)		ce - Amaric ck, Whita, y: Wh			
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Mar	l 2 sh end ls m		19e. Informant's Name/Relationship (t end Number or Rur				Coda)		
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Baltimore,	. Pages 1 end tment of Health tent: If item 27 jury or other t		1 Burial 2 □ Cramation 3 □ 4 □ Donetion 5 □ Othar (Specif		camatar	reen Me	m. (Gardens 5	5/21/98	Finksb	urg,	MD	ta	
3al	Departition Depart		21. Signature of Funeral Sarvica Licar	nsaa		22. Name a HAIGH	nd Addr	ess of Facility NERAL HOM	E & CHAP	PEL (Bo	x 19	5)		
	70 F 4 0		Buar of 9	Harty		Svk	esvi	ille. MD 2	1784 (41	0)-795	-1400)		
			23a. Part1. Entar tha disaasa, or com shock, or haart failure. List only	plications that caused one church on each lin	tha deeth. Do n	not antar tha mod	de of dy	ing, such as cardiac	or raspiratory erra	ıst,		Approx Intarva	I Between	
	Physician /Medical											-	end Death	
	Examiner	disease or condition resulting in death) a. Metastatic Direct Cancer											mont 115	
		ē		1	Dua to (or as a o	consequenca of)	:							
	orted J ansit	Examiner		b		, , , , , , , , , , , , , , , , , , ,					- 1			
<u>,</u>	The law requires that the death certificate be assocuted ate has been signed by the attanding physician and page 2 should be datached for use as the burial-transit	Еха	Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury	· ·	Dua to (or as a c	consequence of)					1			
68760,	e be rsicia													
68	ng phy as th	Medical	rasulting in death) Last											
Box	andim use	N/UE	d											
	thet the death cert led by the attanding datached for use a	Physician/	Part II. Other significant conditions of	iven in Pert I.	Pert I. 23b. Did tobacco use contribute to the cause									
P.O.	by the	Phy							1 □ Ye	2 2 No	3 □ Prol	bably	4 Unknown	
	es the	by			-									
ord	v raquire been si should t	ted							24a. Was an perform	autopsy ned?	24b. Wa	are euto allabla p	psy findings prior to	
ec	as be	ple									of	mplation deeth?	of cause	
<u> </u>		Completed							1 □ Ya	s 2 No	10	☐ Yas	2 No	
ii a	Physician: r this cartific ral director,	Be	25. Was casa rafarred to madical axaminar?					26. Place of Deat	h (Chack only one	9)				
5	\$ 50	ဥ	1 Yas 2 No	Hospital: 1 Inpatiar		tpatiant 3 De	JA		ma 5 Resida	nce 8 □Oth	ar (Specif	y)		
Division of Vital Records,	l or Attending Phi after death. Director: After thi d in by the funeral	OU:	27. Mannar of Death 1 ☑ Natural 5 ☐ Panding	28a. Data of Injury (Month, Day	Yaar) 28b. T		28c. Inju		28d. Dascribe ho	w Injury occur	red			
Sio	Attending or death. ector: After by the fune	cati	2 Accident Invastigation 3 Suicide 6 Could not b			М		Yas 2 No						
<u>></u>	after of Direct of in by	Certification:	4 ☐ Homicida determined		ry - At homa, fai . <i>(Specify)</i>	rm, straat, factor	y, office		28f. Location (Str City or Town,	reet and Numb , Stata)	er or Hura	il Houte	Number,	
	ours and Cilled		One Continue and and an area							4.				
	Hos 24 ho Fun Fun	edlcal	29a. Certifiar 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of ninar: On the basis of end mannar stat	examinetion end	, deeth occurred Vor Investigation	et tha ti	ima, data and place, opinion, deeth occuri	and dua to tha ca red et the time, de	usa(s) and ma eta and placa,	end dua to	tha cau	use(s)	
	To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in	29b. Signature and title of certifier 29c. License number								d. Deta signe	d (Month.	Day, Ya	ar)	
	F3F8		11 0+0 11	$_{0}$ Λ	Λ. A A .					_	10-0	2		
			30. Nama and eddress of person who	completed cause of	eth (Item 23a) (Type Print	100	S1924 ERBERT P 15ter M	HELINA	Son 3	72			
			295 Stoner Av	1 1	307	41054	min	15 fer M	0 2	1157				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registre	r's Signeture	40011	2-48	7100	-/	- / /				
	Registr		MAY 2 0 199	38 July de	r's Signeture	44								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1 Decedent's Nama (First Middle Last) Day **Physician** 0542 Leighann Haines Becca May 1998 /Medical 4b. City, Town, or Location of Death 4a Facility Name (if not institution, giva street end number) 4c. County of Death Examiner Hospital HEDKINS The Johns If Under 1 Year If Under 24 Hrs. CIA 7. Age (In yrs. lest birthdey) 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthpiaca (Stete or Foreign Country) **Funeral** Days Hours Min 1 M 2 XF Yrs **Director** None May 16, 1998 18 Maryland Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6608 Stirrup Court deeth Funeral 21784 U.S.A. 14. Race - American Indian, Black, White, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or then any injury or other traumatic event, the Modical Exertice page. 1 ☐ Yes 2 ☐ No If Yas, Giva A Year or Dates: 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16h Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) None None 0 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumame) Be Chris Haines Amy Hall 19a. Informant's Name/Raiationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mr. & Mrs. Chris Haines (parents) 6608 Stirrup Ct., Sykesville, MD 21784 20b. Place of Disposition (Nema of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Data Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Springfield Cemetery 5/22/98 Sykesville, MD 22. Nama end Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) 21. Signature of Funeral Service Licensee Sykesville, MD 21784 (410) -795-1400 Sykesville, MD 21784 (410) -795-1400 shock, or heart failure. List only one causa on each line. Approximata Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition rasulting in daeth) /Medical a. pulmonary hypertension

Due to (or as a consequence of): 19 hours Examiner Examiner pulmorary hypoplasia (in utero) and I-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that Initiated avants rasulting in deeth) Last physicien a the burielc. congenital diaphrogmatic hernia
Dua to (or es a consequenca of): (in utero) Box 68760. Physiclan/Medical 80 USB 0 ed by the a Pert II. Other significant conditions contributing to death but not resulting in the undariying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown inhavasalar Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed nis certificate hes by 1 ☐ Yas 2 No or Attending Physician: 25. Was case raferred to medical axaminer? Be 26. Place of Death (Chack only ona) To Hospitat: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No ofter death.

Director: A

in by the f 6 Could not be detarmined 28a. Place of injury - At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Streat end Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Dire completely filled in b **Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et tha tima, data and place, and dua to tha cause(s) end mannar stated. 29a. Cartifiar edicai (Check only one) To the Within 2 To the 29b. Signature and title of certifier 29c. Licansa number 29d. Dete signad (Month, Dey, Year) D48128 May 17 1998 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) 600 N. Wolfe St, Baltimore, MD 21287 John M Donnie, mp Me Johns Hopkers Hospital)

State Registrar

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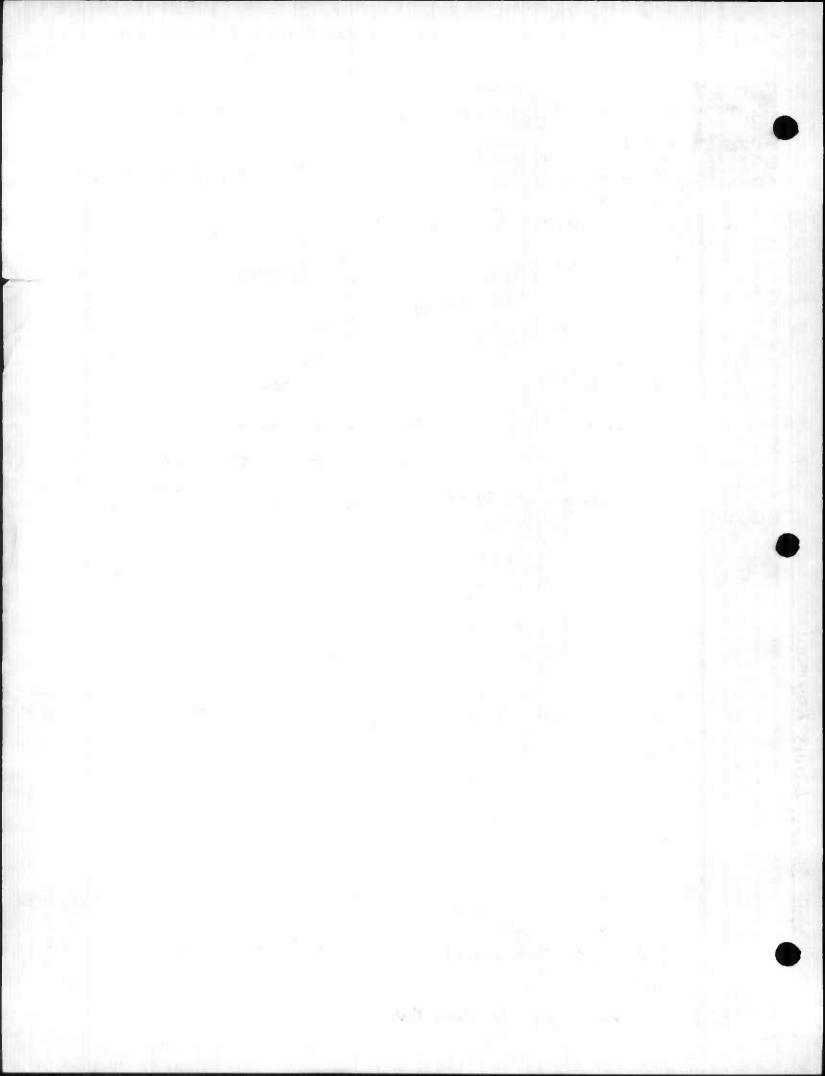


State of Maryland / Department of Health and Mental Hygiene

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andra C. Jones Mathod of Disposition 1	(wife)	901 20b. Place of Dis	Caren Dr		Didie	Mann		
Mathod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe Signature of Funaral Sarvica Lice	Removal from State	20b. Place of Dis	Caren Dr	t and Number or Run	al Route Numbe	er, City or Town,	Stata, Zip	Code)
Mathod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe Signature of Funaral Sarvica Lice	Removal from State	20b. Place of Dis	CULCUI DI	ivo Syko	errillo N	MD 2179/	1	
4 Donation 5 □Other (Spe Signature of Funaral Sarvica Lice Paray Jary	cify)	cemetery, c	position (Name of		Date	20c. Location -		own. State
Signature of Funaral Sarvica Lice Paragraphange		Connet To	ramatory or other pla		140100			
Dauge Hauge	censee	Crest La	wn Mem. G		18/98 N	Marriott	svil	le MD
Jan Charle	- 1		22. Name and Addr	ess of Facility Ha	aight Fa	meral H	iome .	& Chapel
Boot Court	4 Oferber	4	P.O.	Box 195 S				a Chaper
 Part1. Enter tha disaasa, of co shock, or heart failure. List on 	omplications that caused t	the death. Do not e	inter the mode of dy	Ing, such as cardiac	or respiratory ar	rest,	.1704	Approximata
SHOOK, OF Healt landle. List Of	ny one cause on each inte	1,					1	Interval Between Onsal and Death
nediate Causa (Final	(1	13 1
aasa or condition ulting in death)	a sepsi	>						3 days
	7 (Due to (or as a cons	sequence of):				1	3 days 3 weeks
	b. Leukoj	penia					i	3 week
quantially list conditions, ny, laading to immediate	, C	oua to (or as a cons	equance of):					lyear
ise. Enter Underlying use (Diseasa or Injury	. Non S	mall Ce	11 Lung	Carcinom	9		į	1 year
Initiated events	D	ue to (or as a cons	equence of):				1	0
	- 0.						1	
ii. Other significant conditions	contributing to death but	not resulting in the	underlying ceuse gi	iven In Part i.	23b. Did t	lobacco use co	ntributa to	the cause of dear
Ci Oli	01	0			1,250	Yes 2□ No	3 Prot	bably 4 Unkno
Chronic Obst	ructive Fulmo	many Dise	use, Coro	nary				
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Arterial Disease	, Myocardi	ial infare	ition		perfo	rmed?	COI	allable prior to mpletion of cause
	, ,						Ole	death?
					1 🗆 Y	res 2 No	1 [☐ Yes 2☐ No
					(Check only o	ne)		
	Hospital:	t 2 ER/Outpat	ient 3□ DOA Ot	her: 4 Nursing Ho	me 5 Rasid	dence 6 Oth	er (Specif)	y)
	28a. Date of Injury		of 28c. Inju	iry at	28d. Describe t	now Injury occur	red	
		roar, mijur						
3 ☐ Suicide 6 ☐ Could not	ed 28a. Place of injul	ry - At homa, farm,	straat, factory, office				er or Rura	I Routa Number,
4 Homicida	building, atc.	(Specify)			City or Tou	vn, Stata)		
Cartifiar 155 Cartifidae I	Physiology To the best of	mu knowledge de	ath accurred at the ti	ime date and since	and due to the	seven/e) and me		totad
(Check only 2 Medical Ex	aminer: On the basis of a	examination and/or	investigation, in my	opinion, death occurr	ed at the time,	date and place,	and due to	tha cause(s)
	and mainer	904	29c Licen	se number		29d Date sinne	d (Month	Day Vest)
. Signature and tige or denime	1		0	11700		44		
1 1	NO W	7, 0,		11707		May	14,	1998
The B	1	ath /ham 00a) (Tue	o Deint)			1		21220
Name and addrass of person wh	no completed ceuse of de	atn (item 23a) (Typ	e, Print)					01/06/047
0-11 3	4.4	ath (Item 23a) (Typ	STAGNES	HOSPITAL	900 CA	TON B.	altima	ve Mn
Name and addrass of person when thouse B. Date filed (Month, Day, Year)	no completed ceuse of de Mickelso 32. Pegistrar	r's Signatura	e, Print) STAGNES	HOSPITAL	900 CA	TON B.	altimo	ve MD
T T	quantially list conditions, and, leading to immediate use. Enter Underlying use (Disease or Injury at initiated events sulting in death) Last 11. Other significant conditions: Chronic Obst. Article Obst. Was case referred to medical axaminer? 1 Yes 2 No Manner of Death 1 Natural 5 Pending investiga 1 Nostural 2 Accident 3 Suicide 6 Could no datarmine.	quantially list conditions, any, leading to immediate use. Enter Underlying use (Diseasa or Injury It initiated events sulting in death) Last The control of the conditions contributing to death but the control of th	quantially list conditions, any, leading to immediate use. Enter Underlying use (Diseasa or Injury at initiated events sulting in death) Last Due to (or as a consulting in death) Last Due to (or as a consulting in death) Last Due to (or as a consulting in death) but not resulting in the Chronic Obstructive Pulmonary Disease Or Pulmonary Dis	Due to (or as a consequence of): Comparison Due to (or as a consequence of): Comparison Due to (or as a consequence o	Quantially list conditions, any, leading to immediate use. Enter Underlying use (Disease or Injury at initiated events sulting in death) Last Due to (or as a consequence of): On Small Cell Lung Carcinom Due to (or as a consequence of): On Corcinom Due to (or as a consequence of): On Corcinom Due to (or as a consequence of): On Corcinom Due to (or as a consequence of): On Corcinom Due to (or as a consequence of): On Corcinom Due to (or as a consequence of): On Corcinom Due to (or as a consequence of): On Corcinom Due to (or as a consequence of): On Corcinom Due to (or as c	Quantially list conditions, my, leading to immediate see. Enter Underlying use (Disease or Injury at Inflated events sulting in death) Last Due to (or as a consequence of): One of the conditions contributing to death but not resulting in the underlying ceuse given in Part i. Due to (or as a consequence of): Due to (or as accusence of): Due to (or as a consequence of): Due to (or as accusence or accusence of the consequence of): Due to (or as a consequence of): Due to (or as accusence or accusence of the consequence of): Due to (or accusence or accusence or accusence or	quantially list conditions, my, leading to immediate use. Enter Middle of the conditions are consequence of the conditions and the conditions contributing to death but not resulting in the underlying ceuse given in Part I. 11. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 12. Ohostructive Pulmonary Disease, Coronary 12. Was an autopsy performed? 12. Place of Death (Check only one) 12. Place of Injury of Month, Day Year) 13. Pending Investigation and Contributing Pulmonary Part Injury at Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Injury of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of Month, Day Year and Month of	Quantially list conditions, try, leading to immediate use. Enter Underlying use (Disease of Injury at Initiated events sulting in death) Last Chronic Obstructive Pulmonary Disease Coronary 23b. Did tobacco use contribute to the Carcinoma 23b. Did tobacco use contribute to the Coronary 24b. Was an autopsy performed? 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 25b. Did tobacco use contribute to the coronary performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 24b. Was performed? 25b. Did tobacco use contribute to the coronary performed? 24b. Was per

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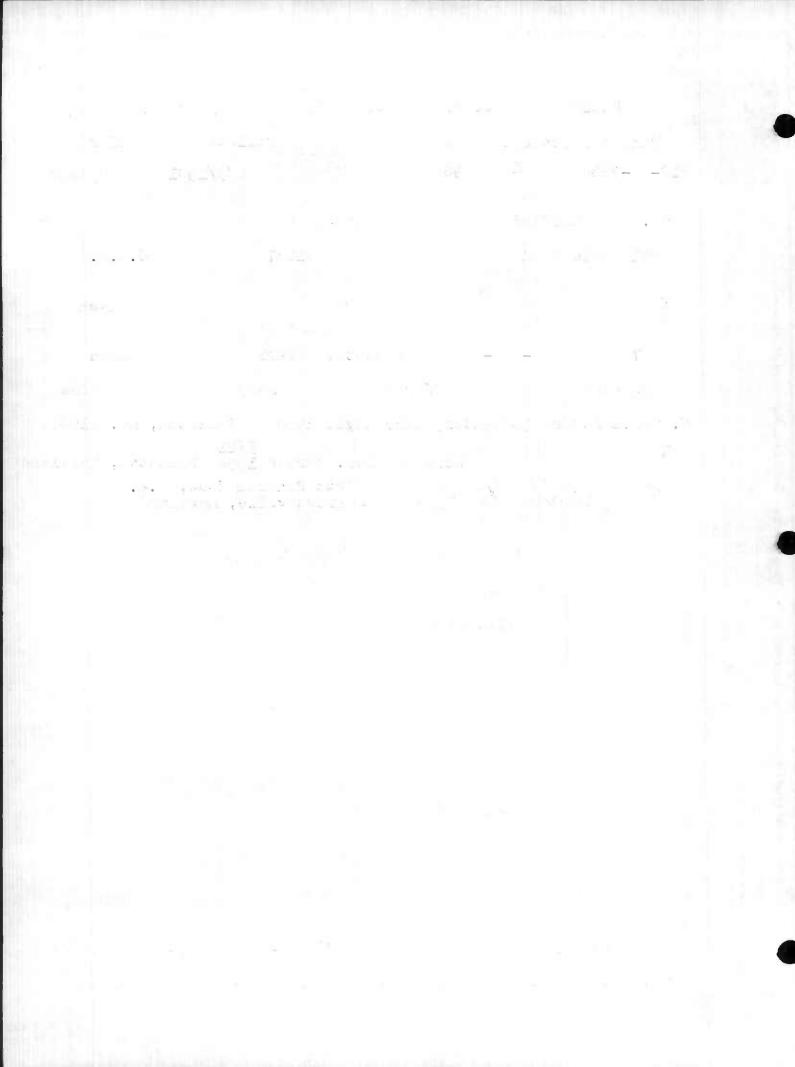
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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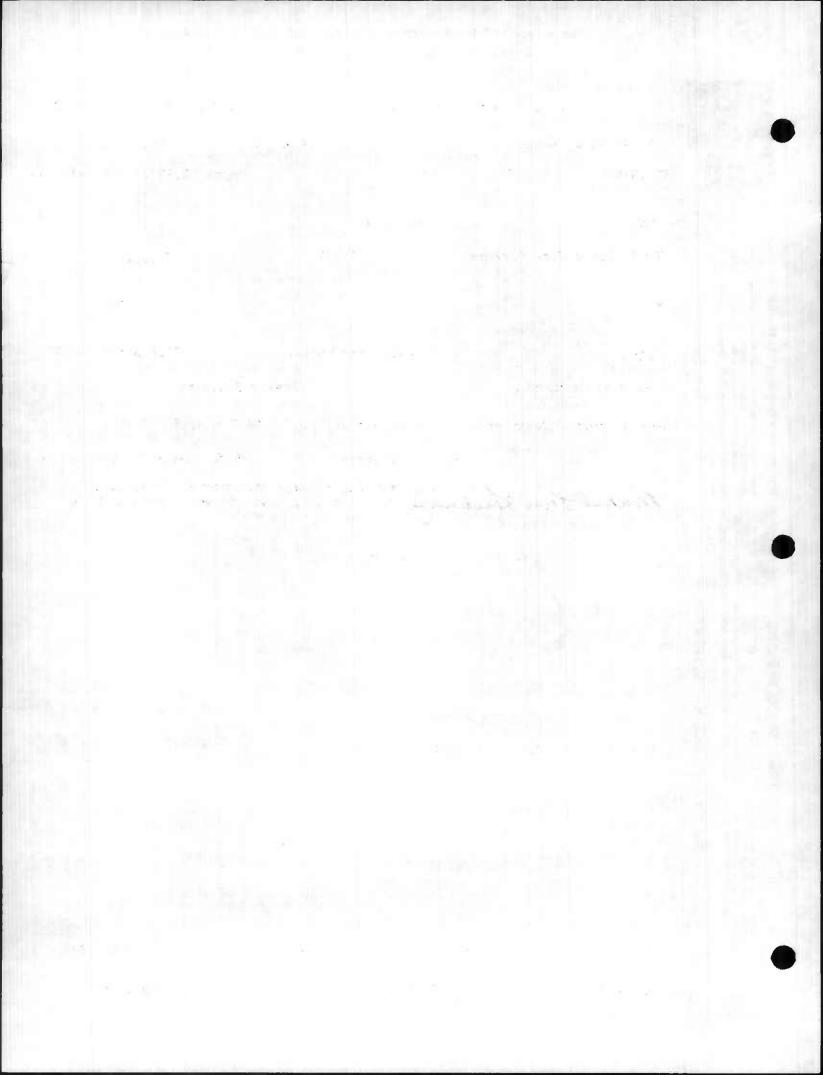
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the Maryle 28a-f sho	ector	Md.	Har	ford	100.0	ny, rown or c	Fall		on		10- Chi		Inside City Limits 1 ☐ Yes 2 🛣 No
3a or	Ö		Engle R	nad			Toi. Zip	Code	21047		10g. Citizen of	J.S.A.	
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Physiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any lojury or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Meritel Stetus 1 ☐ Never Mer 3 ☑ Widowed	rled 2 Married		2 No	J,S. 13	. Wes Deced If Yes, spec		Hispenic Origin? (S pen, Mexicen, Puer	Specify Yes or N to Ricen, etc.)	o- 14. Re	ce - American I ock, White, etc.	Indien,
215-0 hin 72 ho	Be Completed	(Spe	15. Decedent's Ed	ucetion de completed) College (1	1-40r 5+\	16e. Dec (Giv life.	edent's Usue e kind of woi DO NOT us	l Occu k done e retire	pation duning most of wo	rking	16b. Kind of B	Business/Indust	
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yland ould be fil Mental H arked ott atic aver	To Be		(First, Middle, Last)			Jone	8			me (First, Middle	a, Maiden Sumer		lise
Mar 12 sh h and r is m			leme/Retetionship (7		and the state of the				t and Number or Ri				
ges 1 and tof Health If Hem 27		20e. Method of Dis	e Lower;		20b.	Plece of Disponentery, cre	osition (Nem	ne of	Road	Fal. 5/21	20c. Location	Md 2 - City or Town,	
Baltimore, Maryland 21215-0020 pernit. Peges 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic avent, the Medical Examples.		4 Donetion	5 Other (Specify unerel Service Licen:)		Phyle	2. Name en	d Addre	Garden ess of Escility z Fune:	ral Hor	ne, P.A	1.	larylan
Physician /Medical Examine		23e. Pert1. Enter shock, or hee shock, or hee limmediete Cause disease or condition resulting in deeth)	on	_	LATE		Hy1	of dyi	rettsviling, such es cerdiado	c or respiretory	arrest,	Ap	proximete ervel Between set end Death
Box 68760, seth certificate be executed attending physician and for use as the burial-transit	lan/Medical Examiner	Sequentially list or if eny, leeding to in cause. Enter Und Ceuse (Disease or that inlitted event resulting in death)	5		ROSEP Due to (SIS or es e conse	equence of):						
P.O. By that the deeth ed by the ette deteched for	Physicia	Pert ti. Other signi	ficent conditions co	ntributing to de	eath but not res	sulting In the	underlying ca	use gi	ven in Pert I.		/		cause of death
ds, P. (by Pt									1 🗆	Yes 2 No	3 Probabi	y 4 Unknow
aw requ	Completed									24e. Wes	s en eutopsy ormed?	aveileb	autopsy findings ole prior to etion of ceuse th?
										10	Yes 2 No	1 □ Ye	es 2 No
ysiciar ysiciar is certif	o Be	25. Was cese reference exeminer? 1 ☐ Yes 2 ☑	^	Hospitel: 1 1	npatient 2	ER/Outpetie	ent 3 DO	A Oti	her	eth (Check only	one) Idence 6 □Oth	per (Specify)	
On O ding Ph h. After thi funeral	Ition: T	27. Menger of Deet 1 ☑ Naturel 2 ☐ Accident			of Injury h, Dey Year)	28b. Time of Injury		Bc. Inju Wo			how injury occur		
D page	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place building	of Injury - At h ng, etc. (Speci	ome, ferm, st	treet, fectory	office		28f. Location (City or To	(Street end Numi wn, Stete)	ber or Rural Ro	ute Number,
To the Hospital or within 24 hours afti To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)	1 Certifying Phy 2 ☐ Medical Exam	sician: To the iner: On the ba end menn	ISIS Of examine	owledge, deat stion end/or in	th occurred envestigation,	t the ti	me, dete end plece opinion, deeth occu	e, end due to the arred et the time,	ceuse(s) end me dete and place,	enner es steted end due to the	i. ceuse(s)
To the within 2 To the comple	Me	29b. Signeture end	title of certifier	w,	M.D.				se number 15921		29d. Dete signe	ed (Month, Dey,	(Year) 998
∫ sı	ate	30. Name and addr SyED 31. Date filed (Mon		HMOO	e of deeth (Iter	> 4	Print)	Joh	CTHAVENU	E BEL	AIR M	PARYLAND	21014



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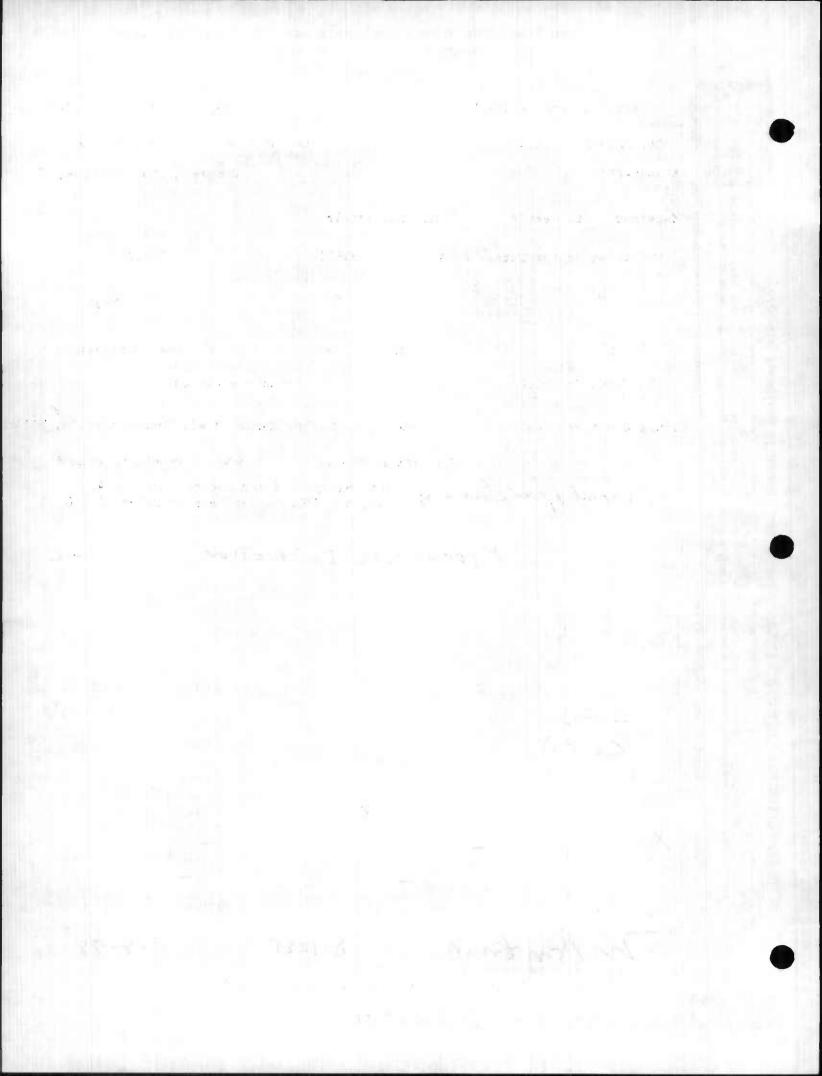
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				Certi	ficate of	Death		Reg. No.	, 1	1602			
I me and the	1. Decedent's Name (First, Middle,	Last)	- 1,7-7				2. Dete of Dee	eth Day	Yeer	3. Time of Death			
Physician /Medical	Lorett	a Elizabeth	n Kulmat	iski			May 1,		1001	17:00			
Examiner	4a Facility Name (If not institution,	give street and number	7)			4b. City, Town, or	Location of Death	4c. County	y of Death				
	407 Military	Lane				Great N	Mills	St.	Mary'	s			
Funeral	5. Social Security Number		ge (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs	s. 8. Dete of Birt	h v. Year)		ace (Stete or Foreig			
Director	187-03-4608 Usual Residence of Decedent	1□ M 2□XF	77_	Yrs.			March	7,1921		nsylvania			
netural, or items 23s or 28s-4 show didal Examinat must be notified at eted by Funeral Director	10a. State 10b. County		10c. City, Tow			17.5			10	0d. Inside City Limit			
oct of	New York		Gle	n Oal				40 000 6					
Dir	10e. Street and Number 7205 Little N	oals Dawlessas			10f. Zip Code 1100	/		10g. Citizen of		.ry?			
23 era	11. Maritel Status	12. Wes Deceden		13 Wa			Specify Ves or No.	U.S.A	A . ce - America	an Indian			
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed Forces	? No		es, specify Cut	Hispanic Origin? (: ban, Mexicen, Pue Specify:	rto Rican, etc.)	Specil	ick, White, e	etc.			
ygiene. ner than "natura nt, the Medical E	15. Decedent's (Specify only highest	Education	16a	. Deceden	t's Usuel Occu	pation	orkina	16b. Kind of B	lusiness/Ind	ustry			
The side	Eiementery/Secondary (0-12)	College (1-4or	5+)	life. DO	NOT use retin	during most of wo	Jiking						
en de la constante de la const	12th			Cafet	eria W	orker		Elemen	ntary	School			
and Mental Hygiene. Is marked other than "natural; summit: event, the Medical Exa To Be Completed by	17. Father's Name (First, Middle, L.	est)				18. Mother's Na	ame (First, Middle,	Maiden Sumai	me)				
Ments arked artic e	Stanley Grob	owski				Adel1	a Jasins	ki					
N Pu	19e. Informent's Name/Reletionshi	p (Type, Print)	198	. Meiling	Address (Stree	t and Number or F	Rural Route Numbe	er, City or Town	, Stete, Zip	Code)			
27 la	Donna Drummond/	Daughter	6	Bava	ard Dri	ve. Dicl	ks Hills.	NY 11	746				
He ette	20a. Method of Disposition			Date		· City or To	wn, State						
Department of Health and Important: If item 27 Is n any Injury or other traun once.	Donna Drummond/ Daughter 20a. Method of Disposition 1												
Physician	23a. Pert1. Enter the disease, of c shock, or heert failure. List o	even Sau omplications that cause his one cause on each	deser Do line.	P. 0). Box	270. Leon	nardtown.	Marvla	and 20				
/Medical xaminer	Immediate Ceuse (Finel disease or condition resulting in deeth)	a. Caro	Due to (or es e						1				
ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	b	Due to (or es a	conseque	nce of):								
ing physicie e as the bur Medical	cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting In death) Last	c	Due to (or es a	conseque	nce of):								
ettendir For use	7.0								i				
he of the s	Part II. Other significant condition	s contributing to death	but not resulting I	n the unde	erlying ceuse g	iven in Part I.	23b. Did	tobacco use co	ontribute to	the cause of deat			
signed by the ettend d be detached for use d by Physician	Bowel 0		1□ Yee 2 No 3□			eably 4 Unkno							
cate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit Completed by Physician/Medical Examin	Bowel O Failure	to The	rive					en eutopsy irmed?	ava	ere eutopsy findings aliable prior to mpletion of cause death?			
ate he							10	Yes 2 No	10	Yes 2 No			
certificate irector, pag	25. Was cese referred to medical					26. Place of De	seth (Check only o	one)					
r this certific and director,	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ER/O	utpetient	3 DOA	ther: 4 Nursing	Home 5 TResid	dence 6 □Ot	her (Specify	1)			
er this eral di	27. Manner of Death	28e. Date of in (Month, D		Time of	28c. Inju			how injury occu					
within 24 hours effer death. To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	1 Neturel 5 Pending 2 Accident investige 3 Sulcide 6 Could no 4 Homloide determin	ot be 28e. Piece of Ir	njury - At home, fa	Injury arm, street	M 1	Yes 2 No	28f. Location (City or Tox	Street and Num vn, Stete)	ber or Rura	l Route Number,			
n 24 hours we Funeral pletely filled edical C	29e. Certifier (Check only one) Certifying	Phyelcian: To the best kaminer: On the basis and manners	of exemination er	e, death o	ocurred at the titigation, in my	ime, dete end pled opinion, death occ	ce, end due to the curred et the time,	ceuse(s) and m date and plece,	anner as st	ated. the ceuse(s)			
Me the	29b. Signature end title of certifier				29c. Licer	se number		29d. Date sign	ed (Month, I	Day, Year)			
3 = 8	PmH. Bu	m B. V.	ロロ.			1893			ay 2,				
	30. Name end address of person w			(Type, Pri	int)								
	Roy H. Bunale	e MD	22225	Fvn1a	ration	II, Lexi	naton D-	mle MD	20652				
State	31. Date filed (Month, Day, Year)		trar's Signature	Rarda	Ц	THE WEAT	- Igeun Fa	servy Will	-400-3-3				



State of Maryland / Department of Health and Mental Hygiene 98 17283

				Certificate	of Death		Re	eg. No.		1 6.00
	1. Decedent's Name (First, Middle, La	st)					Date of Deat	h	Vana	3. Tima of Death
Physician	Frank Joseph	Kendrick				1	Month May 7,	Day 1998	Year	14:24
/Medical Examiner	4e Fecility Neme (If not institution, giv				4b. City, Te	own, or Location		4c. County	of Death	
Funeral Director	St. Mary's Hosp 5. Sociel Security Number 6.5 578-38-8922	oital	(In yrs. last birt	hday) If Under 1 Y Months D		nardtow 24 Hrs. 8. I Min. (n Date of Birth Month, Day, anuary	Yeer)		's ace (State or Foreign y) agton, DC
pue *	Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Town	or Location					10	d. Inside City Limits
vith the Meryle or 28a-f sho be notified at Director	Maryland St. Ma			anicsvill	е					1 ☐ Yes 2X No
or 2	10e. Street and Number			10f, Zip Co	de		10	0g. Citizen of V	Vhat Counti	y?
th w	40 275 New Marke	et Turner R	oad	206	59			U.S.	A.	
d 21215-0020 filed within 72 hours effer deeth with the Meryland Hygiene. wher than "natural, or items 23a or 28a-f ahow ent, the Medical Evantine must be notified at a Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E- Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ver in U,S.	13. Was Decedent If Yes, specify			Yes or No- n, etc.)		- Americe k, White, e	tc.
hour hour be			18a	Decedent's Usual O	ccupation		1	16b. Kind of Bu		
21215-0 ed within 72 ho ygiene. wr than "neturi it, the Med call Completed	(Specify only highest gra	ade completed)		(Give kind of work d life. DO NOT use r	one during mos	st of working				, ,
21215-0020 d within 72 hours of giene. or than "netural", or the Medical Exam Completed by F	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Truck Dri				Beer D	istri	buter
Maryland 212 d 2 should be filed within th and Mental Hygiene. 7 is marked other than fraumatic event, the M To Be Comp	17. Father's Neme (First, Middle, Last, John James Kendi					er's Name (Fin		Aaiden Surnem	е)	
arylan should be and Mental americal ourself even umarice even To Be										
Te, 1 en 1 en 1 ther	19a. Informant's Name/Relationship (Linda Wheeler/Nie 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	ece	4	Mailing Address (S. 0.265 New Disposition (Name v, cremetory or other	Market	Turner	Road		nicsv	ille, MD
Peg Peg ury ury	4 ☐ Donetion 5 ☐ Other (Specif		St. Alo	ysius Cemete	ery	5/9/	98 L	eonardto	wn, Mai	ryland
Baltimos permit. Peges Department of important: if it any injury or o	21. Signature of Funeral Service Licer	- 0	ana D	22. Name and A Matting	ley-Gar	diner				
			he death Do r	P.O. Bo	x 270,	Leonar	dtown,	Maryla	and 20	0650 Approximate
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line).	of eviter the mode of	dying, such a	o cardiac or re-	spiratory arre	551,		Approximate Interval Between Onset end Deeth
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)			d, 1L	DUFA	RETI	0		-	Sec
executed in end initiality in Examiner	Sequentially list conditions	b	ue to (or as a c	consequence of):			-			
68760, tificate be executed to physician end es the buriel-transit	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	uo to for se o o	onsequence of):	_					
	resulting in death) Last	d	00 to (01 as 0 c	orisequence ory.						
deeth deeth	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying ceus	e given in Part	1.	23b. Dfd to	bacco use co	ntributa to	the cause of death?
thet the deeth cented by the ettendiction of the stendiction of the st	CAD						1 🗆 Y	es 2 No	3 Prob	ably 4 Unknow
II Records, P.O. The law requires that the de tate hes been signed by the page 2 should be deteched Completed by Physic	COPI)				-	24a. Was a perform	n autopsy ned?	com	re autopsy findings ilable prior to apletion of cause eath?
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Yital Re ysiclan: The La is certificate he director, page	25. Was case referred to medical examiner?	Hospital:	. XX		Other:	e of Death (C			10 11	
n o n o o o o o o o o o o o o o o o o o	1 Nes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Dey	28b. T		4 □ N Injury at Work? 1 □ Yes 2 □	28d.	-	ence 6 Oth		
Division o To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	Accident 3 Suicide 4 Homicide Investigatio 6 Could not be determined	e One Diese of leive	ry - At home, fa (Specify)	rm, street, factory, of			Location (St City or Town		er or Rural	Route Number,
ne Hospital n 24 hours e ne Funeral I pletely filled	(Check only 2 Medical Exar	ysician: To the best of ninar: On the besis of	examination and							
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ot with	250. Signature and time of certified	n form	0		1428	5	2		8-9	
	30. Name and address of person who	*		Type, Print)			5.0			
State	William Boyd , 31. Date filed (Month, Dey, Yeer)	, II, MD 32. Registrar		nardtown,	Maryla	and 206	50			
State Registrar		8 1998 Jul	-	or Rardall						
DHMH 16 Rev 6/95	WHI V	July July	CAP TON AND AND AND AND AND AND AND AND AND AN							



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. Amended Item 1, Per Phy. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 5/20/98, Carroll County, wil 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death LYDIA CATHERINE KIDD YOAM **Physician** 11998 Kida /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Examiner Westmisster Country (ser arroll If Undar 24 Hrs. . Aga (In yis. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Number 6 Sex **Funeral** Months Days Hours 1 M 2 V Yrs. 100 142-26-3854 **Director** Maryland Usual Rasidance of Decedant with the Maryland 10d. Inside City Limits 10a Stata 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No ykesville Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? I is marked other than "natural", or Itama 23a or traumatic event, the Medical Examiner must be it U.S.A. 21784 2414 permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health end Mentel Hygiena. Important: If flem 27 is marked other than "natural", or thems 23s any injury or other traumatic event, the Medical Examples mass. Funerai 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian 11. Marital Status Black, Whita, atc. 1 Yas 2 XNo If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ₩idowad 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) 16a, Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) Collega (1-4or 5+) Elementery/Secondary (0-12) Registered Nurse Private 11th 18. Mothar's Nama (First, Middle, Meidan Sumema) 17. Father's Name (First, Middla, Last) C. Bradley Ward Cora Schaeffer 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Neme/Relationship (Type, Print) Kathleen Weaver - niece HCR 71 Box 500 Orbisonia, PA 20b. Placa of Disposition (Nama of cematary, crametory or other placa) 20c. Location - City or Town, Stata 20a Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Kriders Cemetery 4 ☐ Donation 5 ☐ Other (Specify) May 19 Westminster, MD 21. Signatura of Funaral Sarvica Licensae 22. Name and Addrass of Facility Burrier-Queen Funeral Directors, P.A. Emple 1212 W. Old Liberty Road Winfield, MD 21784 23a. Part . Itar tha disaasa, or complications that caused the death Do not antar tha mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onsat end Daeth **Physician** /Medical Immediata cau e (Final disaasa or co d tion resulting in de (h) Examiner Examiner lew requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disaasa or injury that initiated evants resulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): 80 USB 23b. Did tobacco usa contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 DOnknown 1 Yes 2 No 3 Probably þ 24b. Wara autopsy findings eveileble prior to 24e. Was an autopsy performed? Completed completion of cause of death? s certificate has b director, page 2 s 1 Yas 2 No 1 Yas 2 No or Attending Physician: 25. Was casa rafarred to medical exeminer? Be 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 2 1- Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding Natural invastigation 1 ☐ Yas 2 ☐ No 2 Accidant after deatl 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 - Homicida To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b 29e. Cartiflar Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and plece, and due to tha causa(s) and mannar as stated. edical 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data end piece, and due to the causa(s) and menner stated. (Check only one)

29c. License number

200 Memorial Ave. W

29d. Date signad (Month, Day, Year)

Westminster, MD

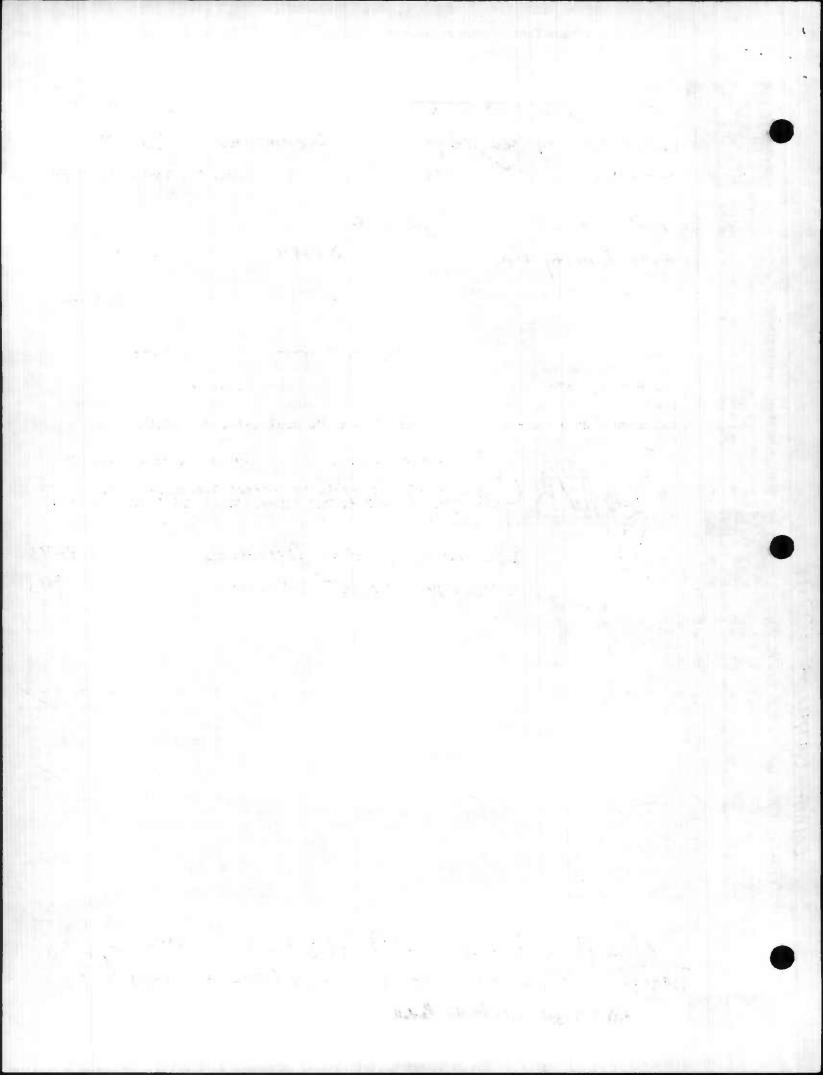
State Registrar 29b. Signatura/and title of certifie

32. Registrar's Signatura 31. Deta filed (Month, Day, Year) MAY 2 0 1998

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30. Nama and addrass of parson who completed cause of death (Itam 23a) (Type, Print)

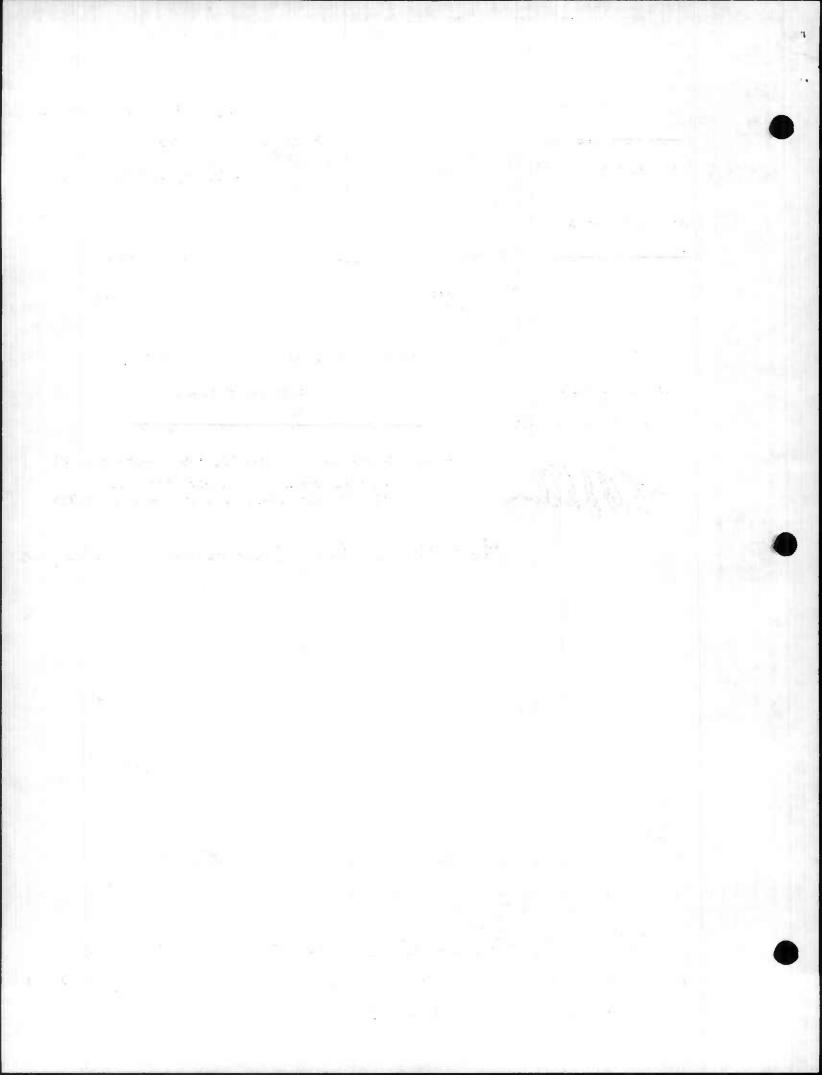
JOSE CATTERION



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 19b, per F.D. 5/28/98, Carroll County, wj1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Otis H. Kirk, Sr. May 1998 9:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5225 Woodbine Rd. 5225 Braddock Rd. Woodbine Carroll If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 215-12-3711 Yrs. Director 76 Sept. 29, 1921 MAryland Usual Residence of Decedent Manyland 10a State 10b County 10c. City, Town or Location "natural", or items 23a or 28a-f show solesi Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Carroll Woodbine the 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 5225 Woodbine Rd. 5225 Braddock Rd. 21797 Funeral United States filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 StYas 2 No 1943 If Yes, Give
Year or Dates: 1946 1 □ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Pages 1 and 2 should be filed within 72 ho nent of Health end Mental Hygiene. ant: If Itam 27 is merked other than "natur ury or other traumatic event, the Medical 15. Dacedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Captain U.S. Army Military 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Charles N. Kirk Maude Loudenslager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number City of Town State, Zip Code)
5225 Braddock Rd, Woodbine, MD 21797 State, Zip Code) Dorothy Kirk (Wife) Woodbine Rd. Woobi ne, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Steta 1 ☐ Burlel 2XX remation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation May 15, 1998 Hampstead, MD 21. Signature of Funeral Service Vices 22 Name and Address of Facility Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. PartY. Enter the dikaasa, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final = years disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner buriel-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the Due to (or as a consequence of): 98 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate hes been signed by page 2 should be detected 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by Records. 24b. Were eutopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? 1 Yas 2 10 No 1 ☐ Yas 2 ☐ No of Vital or Attanding Physician: Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Aesidence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Division 1 Chatural 5 Pending investigation death. 1 Yes 2 No 2 Accident 24 hours efter deatl illed in by the 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es steled.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29e. Certifier (Check only one) the within 2 To the 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 532 Baltimore Bluch Ste 201 Westminster, MD 21157 ass 31. Date filed (Month, Day, Year) State MAY 2 0 1998 Registrar

Amended Item 4a per Phy, and Item 10e per F.D, 5/20/98, Carroll County, wjl

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Van **Physician** 4:27 AM May Jan Lewis Kaiser 1998 15 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Harford Mariner Nursing Home Bel Air If Undar 1 Yaar | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** M 20 F Months Days Hours Yrs. OH Director 277-30-9167 59 03/29/1939 Usuel Residence of Deceden the Maryland 10e Stata 10b. Count 10c. City, Town or Location 10d. Insida City Limits then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21001 611 West Gate Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yas 2 □ No If Yes, Give Yeer or Detes: Vietnam Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11 Maritel Status Bleck, White, atc. hours after 1 Never Married Married 1 ☐ Yes 2 No Specify. Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) filled within 7 Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Factory Industrial Engineer 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be should be and Mental is marked 2 Chester Herman Kaiser Margaret Belle ownit. Pages 1 and 2 sho.
Department of Health and M.
Important: If New 27 is an any injury or office.
SIGS. 19a. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Janice J. Kaiser- Wife 611 W. Gate Rd. Aberdeen, ND 21001 20e. Method of Disposition

1 Buriel 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 5/16/98 West Chester, PA R.A. Ferris & Co. Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Addrass of Facility 21. Signeture of Funeral Servica License Mitchell-Smith Funeral Home, P.A. Tenge 123 S. Washington St. Havre de Grace, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse/on each line. Approximete Interval Between Onset and Death **Physician** Immediete Ceuse (Finel diseasa or condition resulting in deeth) /Medical Examiner Due to (or es e conseque Physician/Medical Examiner sician and bunel-transit certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequença of) been signed by the attending physician should be datached for use as the burie Due to (or es e consequence of) The law requires that the death P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed After this certificate has 1 □ Yes 2 NO Be Director: After this certific in by the funeral director, 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No Certification: To 2 ER/Outpetient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28b. Tima of 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? Attending 1 Naturel 5 Pending investigation 1 Yas 2 No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At homa, farm, street, factory, offica building, etc. (Specify) filled in by or A after 4 Homicide To the Hospital e within 24 hours a To the Funeral D edical 29e. Certifier 12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

— Medical Examiper: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) 29d. Data signed (Month, Day, Year, 29b Signatu

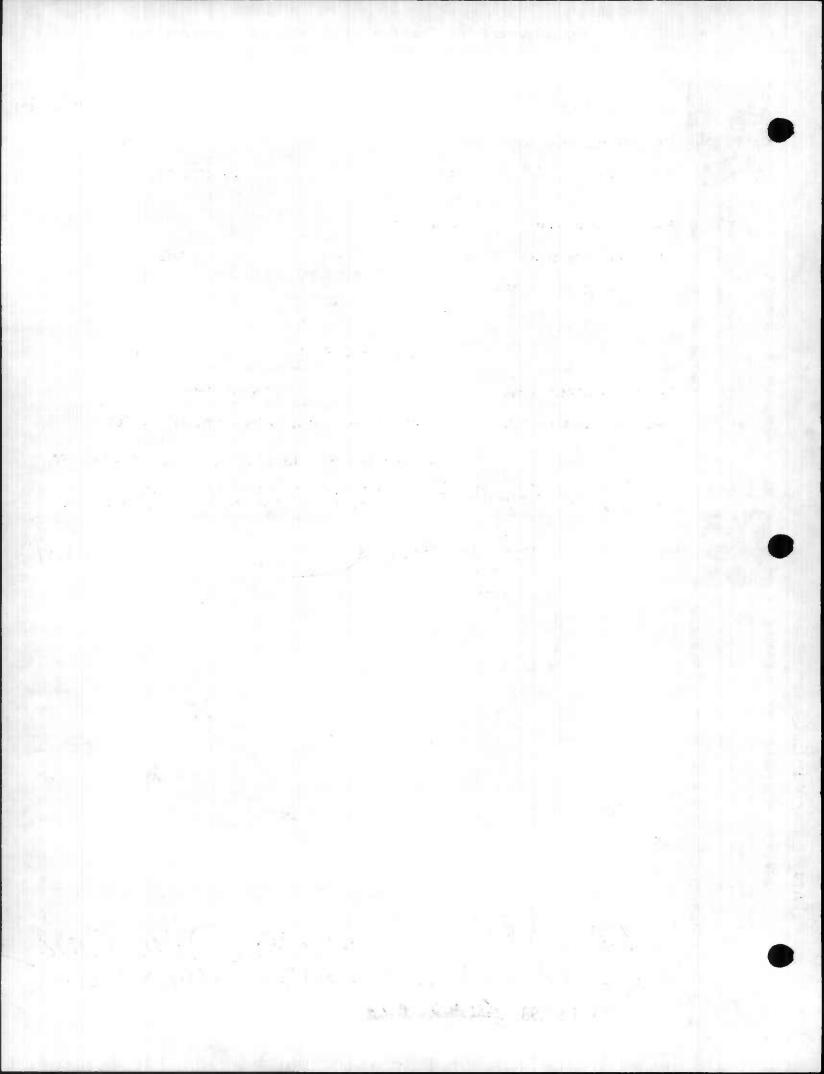
State Registrar

31. Date filed (Month, Dey, Year) MAY 1 8 1998

30. Neme and address of person

32. Registrar's Signeture

ath (from 23a) (Type_Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 15 Elizabeth Lehman Joan MAY 1998 9:00 AM 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death St. Mary's Hospital Leonardtown It Under 24 Hrs. 8 Dat St. Mary's If Undar 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 21XF Days Hours 217-64-8735 47 Yrs. Maryland February 9,1951 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20650 21107 Arbor Court U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: 14. Race - American Indian, Black, White, etc. Was Dacedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Maritai Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Accounting Firm Secretary 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hilda Marie Jennings Mattingly Watts William 19e. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Douglas E. Lehman/Husband 21107 Arbor Ct., Leonardtown, MD 20650 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/19/98 St. Francis Xavier Cemetery Compton, Maryland 21. Signature of Funeral Service Lio 22. Name and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. Jardiner P.O.Box 270, Leonardtown, MD 20650 Filter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 25. Was case reterred to medical examiner? 26. Place of Death (Check only one)

Physiclan /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryfan Department of Health and Mental Hyglene. Important: If Item 27 is merked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, its Menical Eventrice must be notified at

Saltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

JOAN ELIZABETH LEHMAN

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Physician/Medical USB ed by the e by 8 Completed funeral director. Certification: To the Hospital or Attandl within 24 hours efter death. To the Funeral Director: A completely filled in by the to

1 Yes 20 No 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28c. Injury at Work?

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 2 Ccident 5 Pending investigation 3 Suicide 6 Could not ba determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 29b. Signature and title of

4 | Homicide

JAMES

adifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dicai Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. Licansa numbar

death (Item 23a) (Type, Print) 30. Name and add at person who completed can

ARBOE PHILIP J. BEAN MEDICAL CANTER HOLLYWOOD, MD 20636

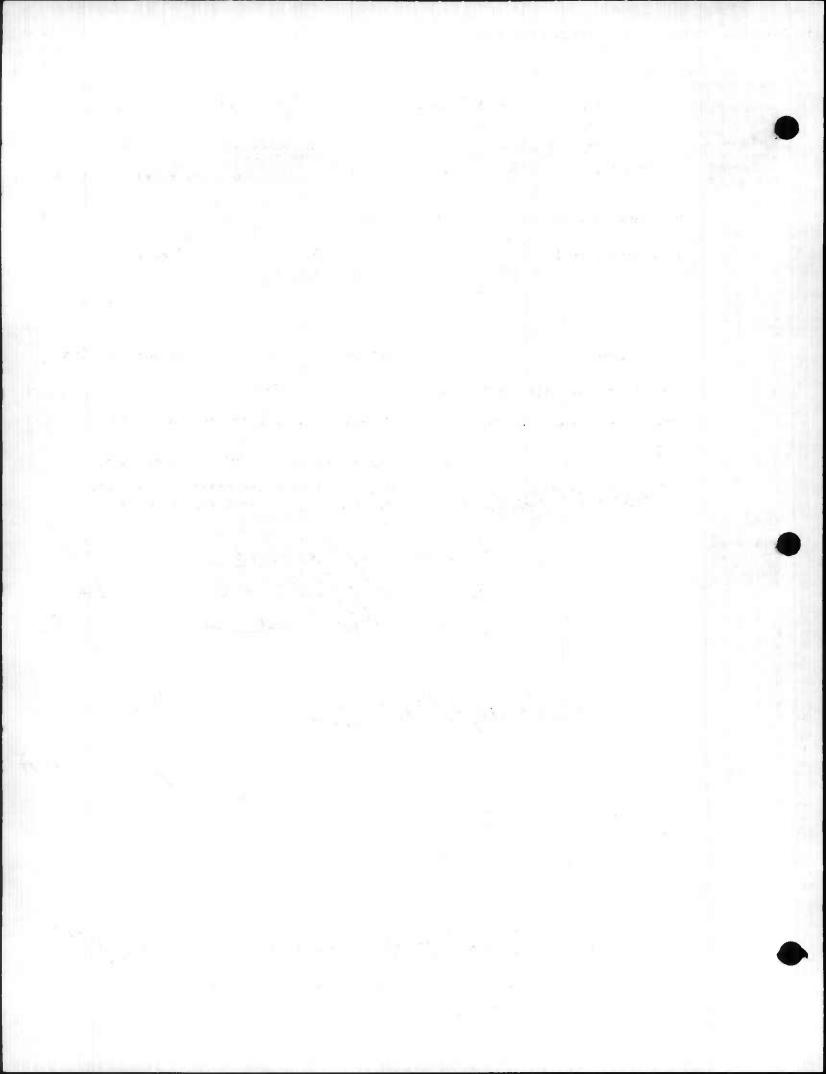
State Registrar

Medical

31. Date tiled (Mighth, Day, Year) MAY 18 1998 32 Registrer's Signature In Davidson Rardall

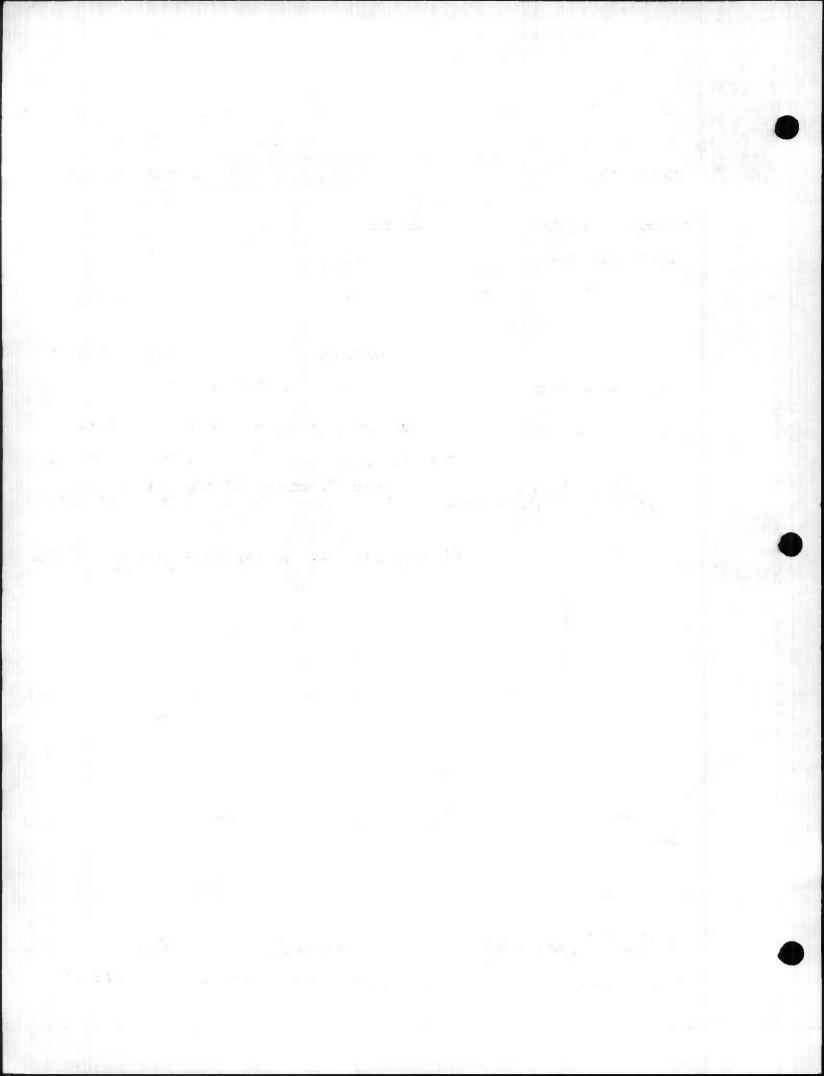
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29d. Data signed (Month, Day, Year)



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Funeral Director	Г	5. Social Security Number 6. S 218-68-0403		rs. last birthday) 44 Yrs.	If Under 1 Year Months Days	if Under 2 Hours		e of Birth onth, Day, Ye	1953	Count	ece (State or Foreign ry) York
ith the Maryland or 28a-f show se notified at		Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10	d. Inside City Limits
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0 28 De no	Director	10e. Street and Number			10f. Zip Code			10g.	Citizen of W	Vhet Count	ry?
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nf', or Herre 23s or 28a-f show Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cube I □ Yes 2√2 No	Specify:	Puerto Rican,	etc.)		e - America k, White, e : Whi	tc.
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r other t		Susan W. Lautz/ V 20a. Method of Disposition	Vife 20k	. Place of Disco	Bennett sition (Name of		Dete	20c	aryLar Location -		
		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from Stete	-	metory or other please Memorial		ens 5-21	-98			aryland
important: If any injury or once.		21. Signature of Funeral Service Licens		22	Name and Address Howard K	s of Facility MCCO	mas II]				P.A. land 21014
119		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ilicetions that caused the de	eeth. Do not ente	or the mode of dying	g, such as c	ardiec or respir	atory arrest,	ALL,		Approximete Interval Between
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physician and the buriel-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Due to	o (or as a conseq	uenca of):						
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attending p	-		d							-	
the att	Physician/M	Part II. Other significant conditions co	ntributing to death but not i	esulting In the ur	nderlying cause give	en in Part I.	23	b. Did tobac	co use con	tribute to	the cause of death?
gned by be detec	by Phy							1 🗆 Yes	70 Mo	3 Probe	ably 4 Unknown
s been s 2 should	Completed						24	a. Was an au performed		com	e autopsy findings lebie prior to pletion of cause eath?
pag								1 ☐ Yes	2 🗆 No	1 🗆	Yes 2□ No
	o Be	25. Wes case referred to medical examiner?	Hospitel:		Othe	ar.	f Death (Chec	1			
Arrer rnis funeral di	-	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 LI Nurs		Besidenca scribe how in			
d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - Al building, etc. (Spe	home, farm, streethy)	eet, factory, office		28f. Loc City	ation (Street or Town, St	and Numbe	er or Rural	Route Number,
To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) Cartifying Phy	sician: To the best of my k nar: On the basis of exami and menner stated.	nowiedge, death nation and/or inv	occurred at the tim estigation, in my op	e, date and pinion, death	place, end due occurred at the	to the cause e time, date a	o(s) and mar and placa, a	nner as sta ind due to t	ted. the cause(s)
To the Funeral completely filled	2	29b. Signature and title of conflier	000		29c. License	number	C	29d, [Date signed	(Month, D	ay, Year)
	ļ	30. Name and address of person who con the control of the control	ompleted cause of death (II	em 23a) (Type, I	Print),	1072	00	—	3//8	118	2 " / /
(0		PANL CAANO,	m,0 6569	N.	Chorles S	street,	BHC	THOR	m	24	209
Sta Registra		MAY 1 9 1998	32. Registrar's Sig	on Rowlett							

DHMH 16 Ray 6/95



10f. Zip Code

Birthpiace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ■ No

Pennsylvania

3. Time of Death

7:00 A.M.

10e. Street and Number 22542 Old Rolling Road

1 Decedent's Name (First Middle I ast)

Physician

Funeral

þ

Completed

with the Manyland

altimore, Maryland 21215-0020

al Hygiena.

permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 Is marked of

Injury or

Physician

/Medical

Examiner

physician and s the burial-trans

BS esn

of Vital Records,

MCCAFFREY, MAE REBECCA

Examiner

Physician/Medical

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Certification: To

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After this

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24 hours after deat Funeral Director:

within 2 To the

any Ir

20619 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Rece - American Indian, Biack, White, etc. Specify: White 16b. Kind of Business/Industry

1998

10g. Citizen of What Country?

United States

St. Mary's

15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12)

1 ☐ Never Married 2 ☐ Married

3 ■ Widowed 4 Divorcad

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress

Restaurant 18. Mother's Neme (First, Middle, Melden Sumeme)

17. Father's Name (First, Middle, Last) Roger Bruce McNemar

Maude Tomlinson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 22542 Old Rolling Road, California, MD 20619

Daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State

19a. Informant's Name/Relationship (Type, Print) Katherine Major,

> 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date

20c. Location - City or Town, State Grace Lawn Memorial Park 5/29/98 New Castle, Delaware

4 ☐ Donation 5 ☐ Other (Specify) Edward N. Brinsfield, JR. M00052

22. Name and Address of Facility Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

2. Date of Death

Month

Immediate Cause (Final disease or condition resulting in death)

Acute Respiratory Failure 2 to
Due to (or as a consequence of):

Due to (or as a consequence of):

10 NOOSAVC Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

				-
Part II. Other significant conditions	contributing to death bu	ut not resulting in the un	derlying cause given in Part	

College (1-4or 5+)

23b. Did tobacco use contribute to the cause of death?

Coronal Arts Discar

1 Yee 2 No 3 Probably 4 □ Unknown

24a. Was an eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 5 Pending 2 Accident

28a. Date of Injury (Month, Dey Year) investigation

28c. Injury at Work? 28b. Time of 1 Yes 2 No

28d. Describe how injury occurred

6 Could not be determined 3 Suicide 28e. Piaca of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide

281. Location (Street and Number or Rural Route Number, City or Town, Stele)

(Check only one)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

05126198.

Komca

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

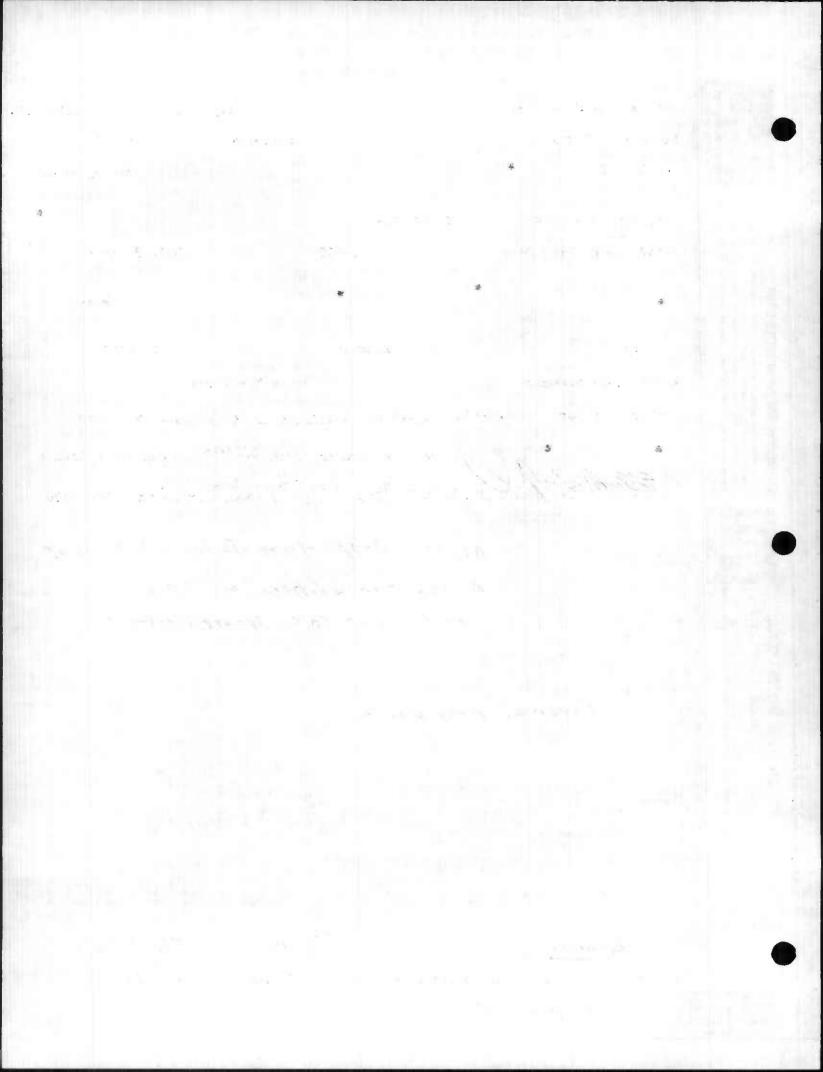
24035 Three Notch Road, Hollywood, Maryland 20636 Kiran D. Mehta, M.D.

State Registrar

31. Dete filed (Month, Day, Year)

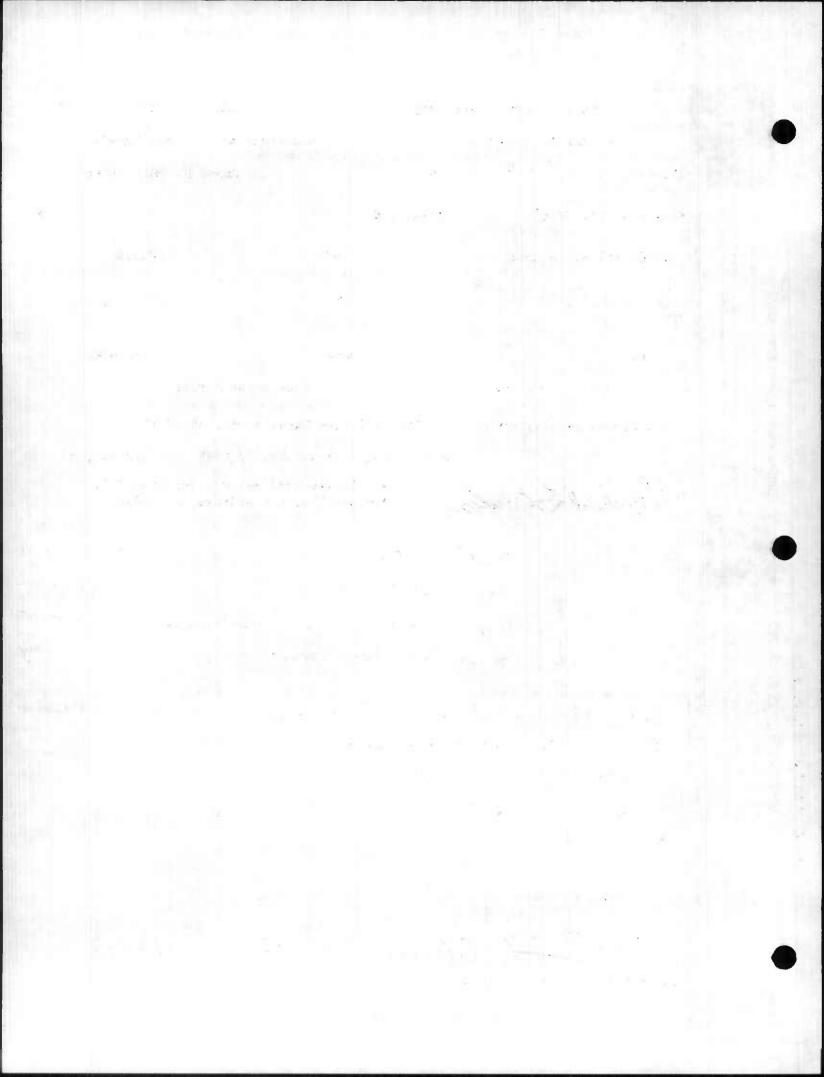
32. Registrar's Signature

Fulin Shudson Rardall



	4
MATTINGLY	Division of Vital Records, P.O. Box 68760.
JEAN	Records
BETTY	f Vital F
NAME:	Division o

	A December 1 Name (First Middle 1 val)	Certificate		Reg. No.	3. Time of Death
Physician	Decedent's Name (First, Middle, Last) Part Table Matter	in a la		lonth Dey Ye	13:30
/Medical	Betty Jean Matt 4a Facility Name (If not institution, give street and number)	ingly	4b. City. Town, or Location		
Examiner	St. Mary's Hospital		Leonardtown		
6		yrs. lest birthday) If Under 1			Birthplece (State or Foreign Country)
Funeral Director	579-22-1433 1 M 2 M F Usual Residence of Decedent	75 Yrs. Months D	Pays Hours Min. (A.	ete of Birth 9. fonth, Dey, Year) Igust 18, 1922 I	Country) `indiana
death with the Maryland ms 23a or 28a-f show final be recitied at neral Director		c. City, Town or Location Hollywood			10d. Inside City Limits 1 ☐ Yes 2 🖔 No
with the Mar a or 28a-f s Les norther	10e. Street end Number 45080 Millstone Lane	10f. Zip Co	6 3 6	10g. Citizen of Whe	
F ribe	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 Yes Size No If Yes No If	r in U,S. 13. Was Deceden If Yes, specify	t of Hispanic Origin? (Specify) Cuban, Mexican, Puerto Rican		American Indian, White, etc.
natural", o	3 ☑ Widowed 4 ☐ Divorcad Yeer or Dates:	16a Decedent's Usuei C	Occupation	16b. Kind of Busin	White mess/industry
Hygiene. wher than "nature ent, the Medical e Completed	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 11th	(Give kind of work of life. DO NOT use if	fone during most of working etired)	Own	Home
工士艺	17. Father's Name (First, Middle, Last)			t, Middle, Maiden Sumeme)	
a de	Fred Harvey		Anne Irene	Mercer	
h end Mer 7 le marke traumatic TO	19a. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (S	treet end Number or Rurel Rou	rte Number, City or Town, Ste	ete, Zip Code)
2 6 6 7	John Thomas Mattingly/Son	3114 Twist	ing Lane, Bowi		
	4 M. Burial Commetica 2 C. Bonneyel from Chate	20b. Place of Disposition (Name cemetery, cremetory or other Charles Memoria	r plece)		
permit. Page Department of Important: If i eny injury or 2006.	21. Signetion of Funeral Service Licensee,		Address of Facility gley-Gardiner x 270, Leonard		
hysician	23a. Part1. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line.				Approximete Interval Between Onset and Death
/Medical Examiner	resulting in death)	- crisis		V For part process of the second	10 days (1 monte
n and isi-transit Examiner	b. Acute	e to (or es a consequence of): Leukemia			(1 mont
icien and burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	o to (or es a consequence of):	wh resistan	t anemia	6 month
nding physicien use as the buria	that initiated events resulting in deeth) Last	obysplasia to fores a consequence of): e Thrombocy	topenia		12 days
attending for use a Iclan/M	Pert II. Other significant conditions contributing to deeth but no			23b. Did tobacco usa contri	lbute to the cause of death?
signed by the all d be detached to d by Physic					□ Probably 4 □ Unknown
cate has been signed by the attending page 2 should be detached for use a Completed by Physiclan/M	Cellulitis Right Chronic Obstructure	Pulmonar	y Disease	24e. Was en autopay performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
page 2	Hypoalbuminemia,	anemia,		1□ Yes 2 No	1 ☐ Yes 2 Ø No
is certificate director, pag To Be Co	25. Was case referred to medicat examiner?		28. Plece of Deeth (Ch		
After this funeral di	1 Yes 2 No Hospital: 1 Impatient 27. Manner of Death 1 Neturei 5 Pending 2 Accident Accident Accident Pending Accident 2 ER/Outpatient 3 DOA 28b. Time of Injury M		5 Presidence 6 Other Describe how Injury occurred		
within 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	2 □ Fuiside 6 □ Could not be	- At home, farm, street, factory, of pecify)		ocation (Street end Number City or Town, State)	or Rural Route Number,
24 houn Funere letaly fille dical C	29a. Certifier (Check only one) 1 Certifying Phyelcian: To the best of many one and menner stated	amination end/or investigation, in			
To the compl	29b. Signeture and title of certifier	29c. L	icense number 00 5 1 7 3 8	29d. Date signed (1	
	30. Name and address of person who completed cause of deeth	73101111			1
State Registrar	31. Date filed (Month, Dey, Year) MAY 2 9 1998 32. Registrar's	Signature Avulsor-Rardall			



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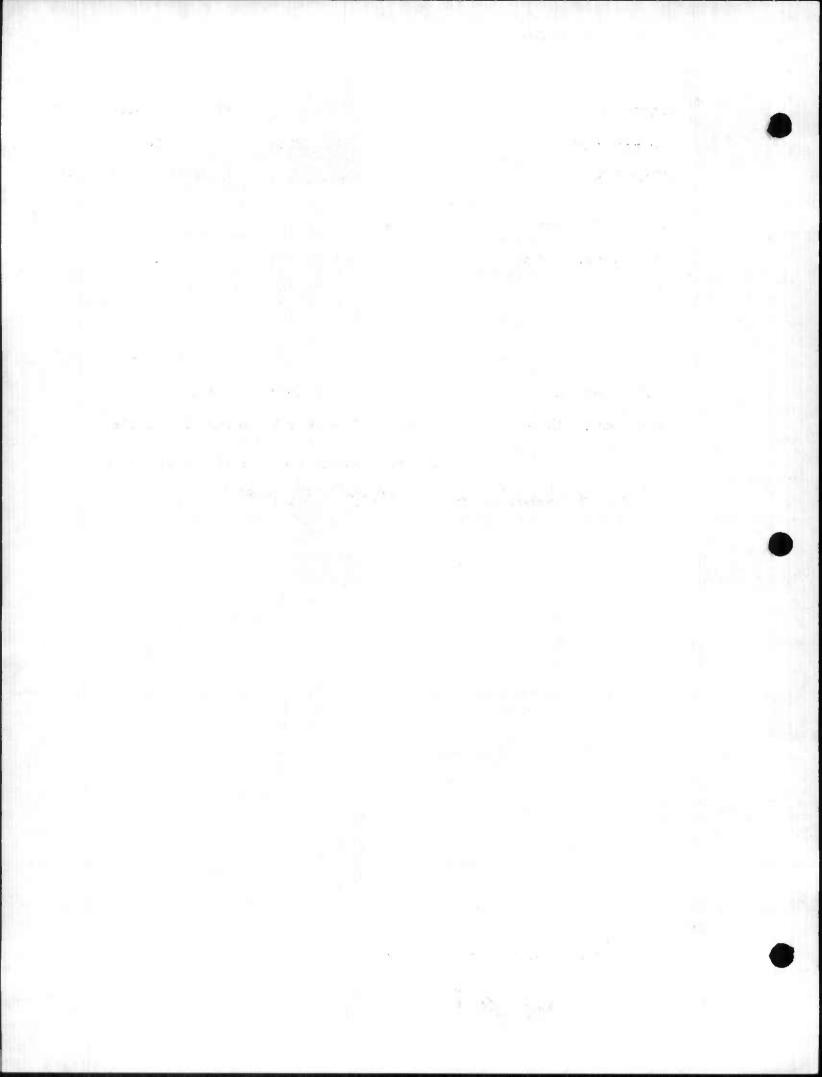
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r tems 23e or 28a-f s circe must be notified Funeral Director		10e. Street and Number					10f. Zip	Code				10g. Citiz	zen of Wi	hat Country	y?	
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THE P		19a. informant's Name/Ralationship	(Type Print)		191	Mallin	n Addrass	(Street			al Routa Numi		r Town S	State Zin C	ode)	
trau					-		_	-							000)	
E 2	-	Kathy Mezei- Nie	ce		20b. Piaca o				St #2	2 06	enver,		802		Charle	
of H	1	20a. Mathod of Disposition 1 ☐ Burial 2 X Cremation 3 [Removal from		cemata	ry, cram	natory or o	othar pla	ca)	1	Data	20c. Lo	cation - C	City or Town	n, State	•
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ysician Medical aminer		tmmediata Causa (Final disease or condition rasulting in daath)	a		= 57/ a to (or as a			18.	ART		FA	7/6	URI	5		
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y the iched	. '	Part ii. Other significant conditions of	contributing to t	death but i	iot resulting i	n that un	ioarrying c	ausa gr	van in Part							
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5 -	-	27. Mennar of Death	28a. Data		2 ER/O	itpatient		JA	ALPRI IAI	ursing Ho	oma 5 Ras					
al Director: After this ed in by the funeral Certification: 1	ľ	1 Naturai 5 ☐ Panding Invastigatio	(Moi	nth, Day Y		injury	M	28c. inju Wo 1 □	rk?]Yas 2□	No	200. Dascino	be how injury occurred				
d in by the		3 ☐ Suicide 6 ☐ Could not be data mined	286. PIGC	e of injury ding, atc. (- At homa, fa Specify)	ım, stre	et, fector	y, office			28f. Location City or To	(Street and own, State)		r or Rural F	Pouta ∧	lumber,
To the Funeral Dir completely filled in Medical Cert		29a. Certifiar 1 Certifying Pt (Check only one)	miner: On that	a best of m basis of ax nnar stated	amination an	a, daath id/or inv	occurred astigation	at the ti	ma, data ar opinion, daa	nd place, ath occur	and dua to the red at tha time	a causa(s) , data and	and man place, a	nar ae stat nd dua to th	led. ha caus	se(e)
o the		29b. Signature and #119 of certifier					290	c. Lican:	sa nu <i>m</i> ber		T	29d. Date	a signed	(Month, De	ay, Yea	r)
F 0		1 18 3	1	1	1								1	/		
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10	3	30. Nama and addrass of person who	complated cau	usa of daat	h (itam 23a)	(Type, F	Print)									
State	3	31. Data filed (Month, Day, Year)	32	ie istra	Signature	0 .										

Registrar





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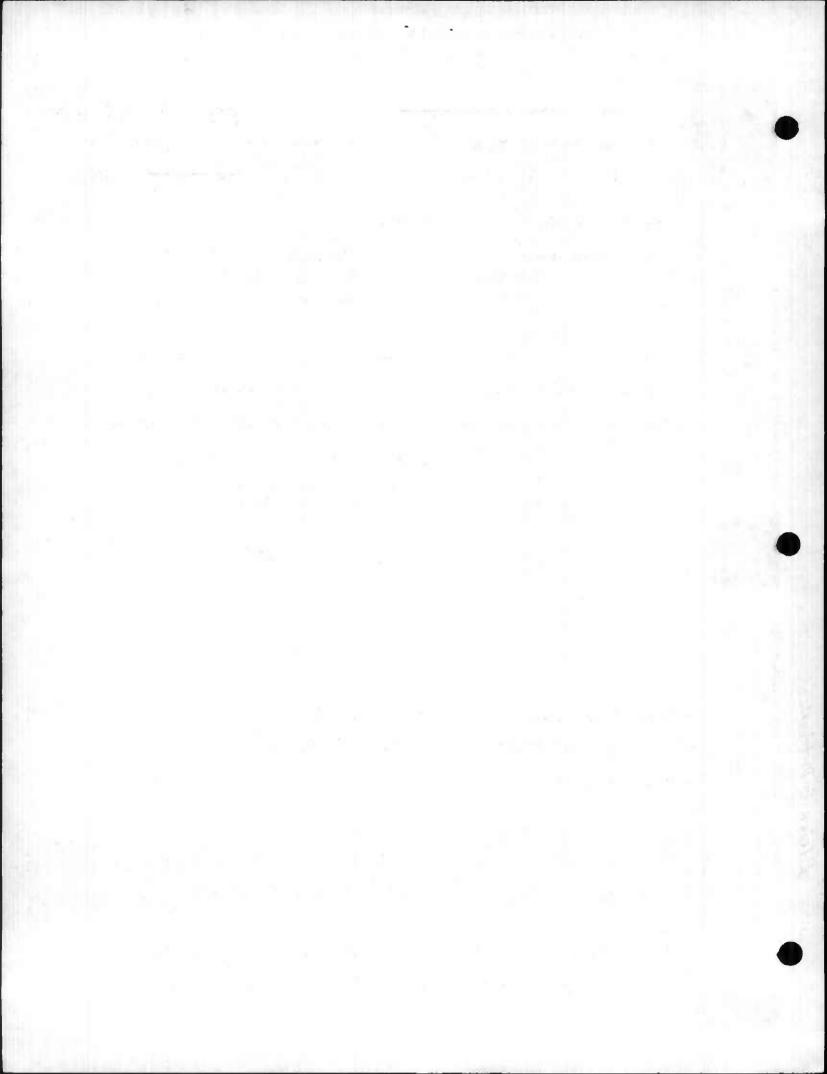
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) LILLIAN FRANCES BERRY MITCHELL 3. Time of Death 2. Date of Death **Physician** Month Frances Berry MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Peath 4c. County of Death **Examiner** CITIZENS NUESING HOME HAVEE de GEACE HACTOED 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dele of Birth (Month, Day, Birtholaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) 1 M 2 X F Yrs Director 213-05-8284 1910 Virginia Usual Residence of Decedent Sept. 08,1910 the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Medical Examiner must be notined at 1 Yes XXNo Director Harford Churchville Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 5 Rockdale Avenue 21028-1615 U.S.A. Funeral permit. Pegas 1 and 2 should be filed within 72 hours efter death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Cleveland Berry Nancy Louise Absher 2 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn M. Rhinehart (DAughter) 5 Rockdale Ave., Churchville, MD 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date any injury or c 1 ☐ Burlai 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 5/13/98 West Chester, PA. 21. Signeture of Fune Service Licansee 22. Name and Address of Fecility
Tarring-Cargo Funeral Home, P.A. 21001-3399 Aberdeen , MD nel 600 23a. Parl 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Physician tmmediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequenca of) Examiner The law requires that the death certificeta be executed attending physician and for usa es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): datached for the Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contributs to the cause of death? Unknown signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably py 99 OKARY ARKERY AS 24b. Were autopsy findings aveileble prior to completion of cause of death? - KARIC 11/06/ 16 24a. Was an autopsy performed? page 2 should Completed peed cartificate has TERTENSION 1 ☐ Yes 2 Z No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ tnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) P aftar death. Director: After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury at Work? Certification: 5 Pending investigation Natural
Accident 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 8 To the Hospital of within 24 hours as To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address (Item 23a) (Type, Pri SIDNO

Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

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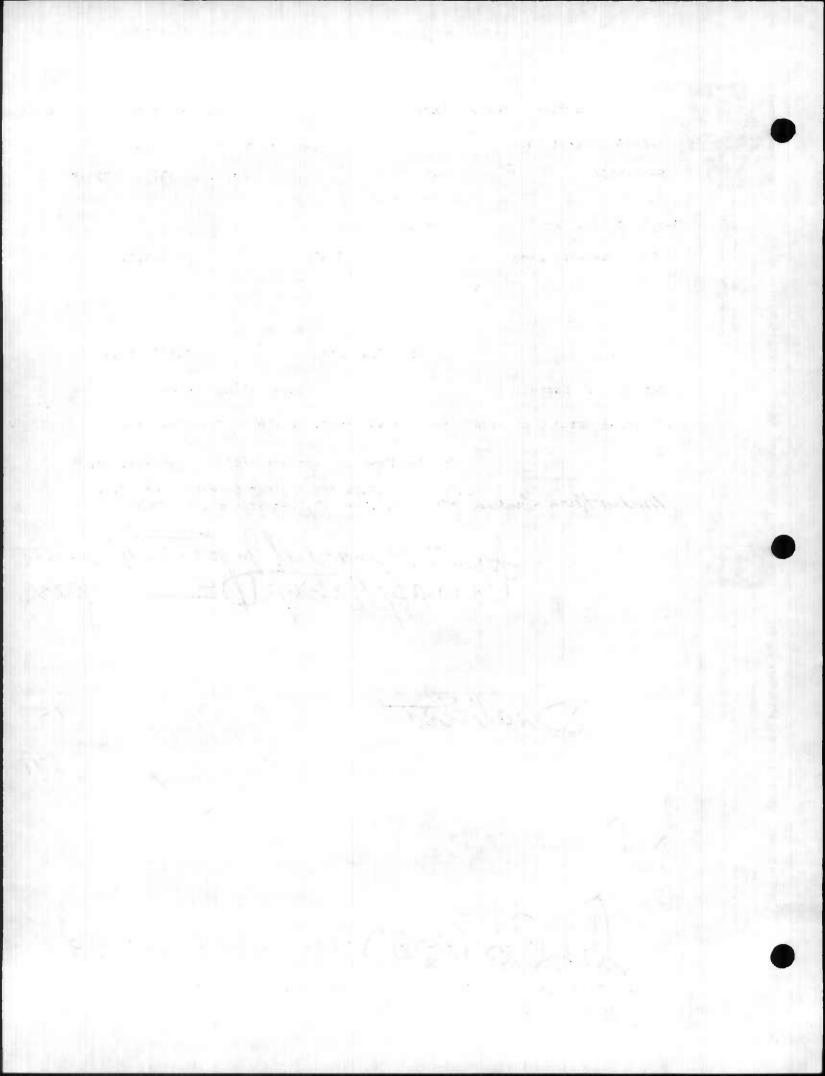
LILLIAN B. Mitchell



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

44 Facility Name (If not institution 45843 Kryst 5. Social Security Number 216-40-5488 Usual Residence of Decedent 10a. State 10b. Count 10a. State 10b. Count 10c. Street and Number 45843 Kryst 11. Maritel Status 1 Never Married 2 Ma 3 Widowed 4 Divorce (Specify only high Elementary/Secondary (0-12) 12 th 17. Fether's Name (First, Middle George C. 19e. Informant's Name/Relation	artha Ma on, give street and n cal Lane 6. Sex 1 M 2 M F Mary's al Lane 12. Wes De Armed F 1 Yes, G Yeer or ont's Education est grade completed College College a, Last) Russell Inship (Type, Print) ie Clarke Specify) e Licensee Complications that or complications that	7. Age (In yrs. In 6 10c. City Le seedent Ever in U.S. Forces? S 2 (X) No Give Dates: d) (1-4or 5+) Chaughte Cha	y, Town or Loc xingto S. 13. W 16a. Deceding to the life. D Head 19b. Mailing t 466 lace of Disposemetery, crem rles Ma	If Under 1 Year Months Days D	Hours Min. 153 Hispanic Origin? (Span, Mexican, Puertic Specify: Pation during most of word) 18. Mother's Nan Rose At and Number or Ruer of the Gardens	B. Date of Birth 8. Date of Birth (Month, De) Sept. 7 Decity Yes or No- Decity Y	Day 5, 1998 4c. County St. 7, Year) 10g. Citizen of W U.S. 14. Race Specify 16b. Kind of Bu Board of Maiden Sumem uite or, City or Town, Rd., Le: 20c. Location Leonard	of Deeth Mary's 9. Birthplea (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No What Country? A. e American Indian, ook, White, etc. White usiness/industry f. Education
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30. Neme and aderess of person	KH	suse of death (item	23a) (Type, F	Print)	ardtown,			5-78
2	examiner? 1	1 Yes 2 No 27. Menner of Deeth 1 Natural 2 D'Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Yes 2 No Hospitel: 1 28a. Dat (M. (M. (M. (M. 28a. Det (M. 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined 28a. Ple determined	examiner? 1	examiner? 1	examiner? 1	examiner? Yes 25No	24a. Wes case referred to medical examiner? 1	examiner? Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Ot

Registrar
DHMH 16 Rev 6/95



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 294 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** May 9, 1998 12:53 PM Danial Benjamin Nelson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Mary's 21346 Arthur Lane California If Undar 24 Hrs. 6. Data of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. lest birthdey) Birthpiace (State or Foreign Country) **Funeral** 1 M 2□ F Months Days Yrs. Director 264-88-7282 50 June 17, 1947 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examiner must be notified at the 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yes 2 X No Directo Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21346 Arthur Lane 20619 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☒ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Waterman Seafood 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Joseph Edward Nelson Elizabeth Gene Poe 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) P.O. Box 1064, La Plata, MD 20646 Sheila J. Nelson/Sister 20b. Placa of Disposition (Neme of cemetery, cremetery or other p. 20a. Method of Disposition 20c. Location - City or Town, State St. George Island United 1 Burial 2 □ Cremation 3 □ Removal from Stata 5/12/98 St. George Island, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Methodist Church

22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.

Maryland 20 Lardiner P.O. Box 270, Leonardtown, Maryland 20650 une Part 1. Enter the disease, or complications that caused the daath. Do not antar tha mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examine. Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in daath) Last Physician/Medical Due to (or as a consequence of): 98 950 for signed by the a 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed certificata hes b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Other: 4 ☐ Nursing Home 5 【 Pasidance 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Death 28a. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending

The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records, Attending Physician: funeral After death. octor: Direc • Funeral Dire letely filled in b ò Medicai To the Hosp within 24 hos To the Fune completely fi

Baltimore, Maryland 21215-0020

2 Accident

invastigation 6 Could not be determined

28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street end Number or Rurel Route Number, City or Town, State)

(Check only one) 29b. Signatura and

3 Suicide

29a. Certifier

4 Homicide

1/2 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

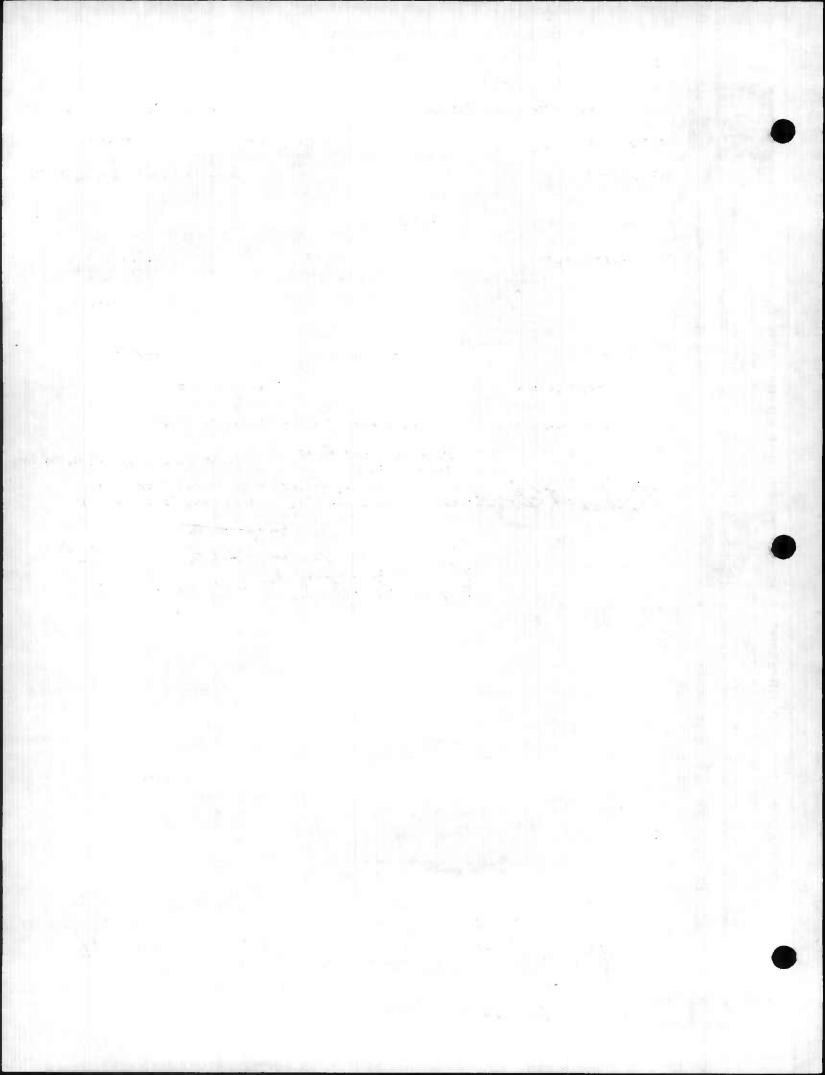
2 Medical Examinar; On he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner spited.

29d. Date signed (Month, Day, Year)

of person who mpleted cause of death (item 23e) (Type, Print) 30. Name and address atrick Jarbee, MD th, Day, Year)

Hollywood, Maryland 20636

State Registrar 32 Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item 4a, per Phy. State of Maryland / Department of Health and Mental Hygiene 5/20/98, Carroll County, wjl Certificate of Death Physician 1. Decedent's Name (First, Middle, Last) Henry Herbert Newman, Sr. Physician Month May 17, 1998

3. Time of Death

3:05pm

Physician /Medical Examiner Funeral

2	Examir	ner	6503 I		Brae Roa		6503 1 BRAE 1		•		svil	le.		roll	h	
	Funeral Director	Г	5. Social Security N 147–16–9 Usual Residence of	9190	6. Sex M M 2□ F	-	'In yrs. last birthda 72 Yrs.		1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan 1	th ay, Year) , 1926	Co	hptace (Stete buntry) York	or Foreign
	r 28a-f show	tor	10a. State	10b. County	rroll	1	Oc. City, Town or	Location kesvil	le						10d. Insida C	ity Limits
	th with the 23e or 28	al Director	10e. Street and Nu		ae Road			10f. Zip	Code 217 8	34			10g. Citizen of What C			1
070	er dee items	by Funeral	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		ried Yes	Forces? s 2 \(\subseteq \text{No} \) Give	er in U,S. 1:	l. Was Deced If Yes, spec 1 ☐ Yes 2			gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	Spec	lack, Whit	rican Indian, e, etc. hite	
0200-61212	e filed within 72 hours eft al Hygiene. other than "naturel", or vent, the Medical Exam	Completed	(Spe	cify only highe	t's Education st grade complete College	d) (1-4or 5+)	(Gi	edent's Usue re kind of wor DO NOT us	rk done d se retired	du <i>ring</i> most f)						
ryland	Ment barked	To Be C	17. Father's Name Henry H. 19e. Informant's N	. Newma	n		10h Ma	ilina Addraes	(Street	Is	abel	le Co	, Meiden Sum ote er, City or Tow		Zin Codo)	
Baltimore, Mal	tem 27 is		Mrs. Le: 20a. Method of Dis 1 XBurial 2	ida New	man (wif			3 Bonn position (Namematory or or	ie E	Brae F	Road	Sykesv Date	ille, N 20c. Location Sykesy	1D 21	784 Town, Stata	
pall	permit. Peges Department of Important: If I eny Injury or		21. Signature of Fi	ian	d. Ha	glt.	-	Svkevi	FUN	TERAL MD 2	HOME 1784	(410)	PEL (Bo -795-14		5)	
V	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.											Approxima Interval Be Onsat and	tween	
	/Medical Examiner	Je.	Immediate Cause (Final disease or condition resulting in deeth) e. COPO Due to (or as a consequence of):										10	103		
Ď,	icete be executed physician and s the buriel-trensit	Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease o	onditions, mmediate erlying	b	Du	ue to (or as a cons	equence of):								
BOX 68/60	nding use e	Physician/Medical	C. Due to (or as a consequence of): d.													
	b ethe d															
Vital Hecords,	e law requires thet hes been signed I ge 2 should be det	Completed by									. —	24e. Wes	en autopsy ormed?		Were autopsy available prior completion of of death?	to
I E	는 음 점		25. Was case refe	ssed to medica	·				_		15 4		Yes 20 No		1 Yes 2] No
	Physician: this certific	To Be	examiner2	No	Hospital	☐ Inpatient	2 ER/Outpat	ent 3 DO	Oth			ne 32 Resi	idence 6 🗆 C	ther (Spe	cifv)	
Jivision of	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Certification: 1	27. Manner of Dea	5 Pendir investi	28a. Da (Mo	te of Injury onth, Dey Y	28b. Time	of 2	8c. Injur Wor 1 🗆		No	28d. Describe	how injury occ	urred		
	ital or Ath irs efter de ral Direct		3 Suicide 4 Homicide	6 ☐ Could determ	ined 200. Pla	ce of Injury Iding, etc. (- At home, farm, (Specify)	street, factory	, offica		1		Street end Nu wn, Stete)	mber or R	urel Route Nur	nber,
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	fedical	29a. Certifier (Check only one)	2 Medical			caminetion and/or	Investigetion,	, in my o	pinion, dee			date and plec	e, and due	to the cause(s)
	Veiti To Cor	Σ	29b. Signatura and	Roth	schile	1 /2	D.	-	D4	827	5		29d. Data sig	9-9	2	
	S.		30. Neme end edd M. Roth 31. Dete filed (Mor	schilo	I.M.D.	532 Registrar's	Bait.	e, Print) RIVA	V	Vest	muns	ster 1	40 2	2115	7	
Ĭ	Sta Registr	-		AY. 2 0	1998 Jul	* Die	s Signature	4								

and the second by

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** May 10, 1998 Katherine Claire Radford 10:00 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dameron

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 49930 Raley Road St. Mary's If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 1 M 2 XF Months Deys Yrs. 42 215-64-5748 August 12, 1955 Maryland Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo St. Mary's 49930 Raley Road Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 49930 Raley Road 20628 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Maritel Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 X Married 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Yrs. Registered Nurse Nursing Center 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P Phillip H. Hurry Katherine L. Greenwell 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) William B. Radford/Spouse P.O. Box 174, Dameron, Maryland 20628 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremetion 3 Removal from Stete 4 ☐ Donalion 5 ☐ Other (Specify) St. Michael's Cemetery 5/14/98 Ridge, Maryland 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest,

Approximately a street failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest to (or es a consequence of) 1 Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilebte prior to 24e. Was en eutopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 ₹ Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 27 Manner of Deeth Certification: 28c. injury et Work? 1 XNatural

certificate be executed attending physician and for use es the bunal-tran P.O. Box 68760 the detached signed by t Division of Vital Records. has director, this uneral After al or Attending P s aftar death. Il Director: After t

Funeral

Director

hem 27 is marked other than "natural", or frams 23a or 28a-f show other traumatic awant, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or Itama 23a any Injury or other traumatic avant, the Medical Examinal most page.

Physician /Medical

Examiner

Saltimore, Maryland 21215-0020

with the Marylend

5 Pending Investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Tyes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner stated.

(Check on one) 29b. Signetur

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifie

29c. License number

29d. Date signed (Month, Day, Year)

ed cause of death (ttem/23e) (Type, Print), 30. Name and address of person who come Patrick Janboe, MD

Hollywood, Maryland 20636

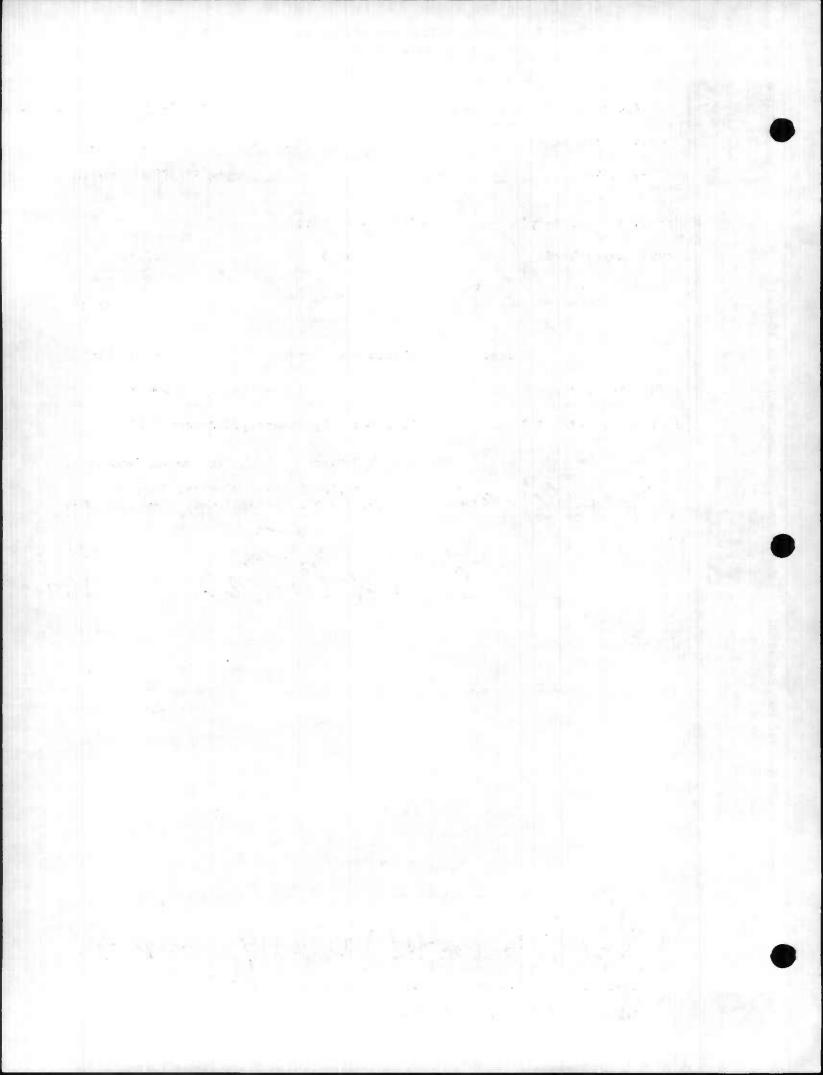
State Registrar

3

edical

To the Hospital within 24 hours a To the Funeral C Hospital

> 31. Date filed (Month, Day, Year) 32. Registrer's Signeture Jak Daviden Rardall.



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death May 12, 1998 **Physician** 5:07 PM William Junior Redmond /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 45713 Oregon Way Lexington Park St. Mary's H Under 1 Yeer | H Under 24 Hrs. | 8. Dete of Birth (Month, Pay, Year) 9 3 4 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 577-48-8874 63 Yes Maryland Director Usual Residence of Deceden 10a Stete 10b County 10c City Town or Location 10d. Inside City Limits with the Maryle item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ■ No St. Mary's Maryland Lexington Park Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20653 45713 Oregon Way United States 2 should be filed within 72 hours after deeth in and Mantal Hygiene.
Is marked other than "natural", or items 23s Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Stetus 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ■ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify: White à 3 Widowed 4 Divorcad Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Lithographer/Photographer Printing 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Ethel Brightwell Harry Redmond 70 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 end 2 sh Depertment of Health and Important: If Item 27 is m eny injury or other traum pnce. 45713 Oregon Way, Lexington Park, Maryland 20653 Laura Redmond, Wife 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removel from Stete 5 Other (Specify) 5/15/98 Charlotte Hall, Maryland All Faith Episcopal 4 Donation 22. Name and Address of Facility
Brinsfield Funeral Home, P.A. 44 Rizzo 22955 Hollywood ROad, Leonardtown, MD 20650 M01114 that caused the death. Do not enter the mode of dyling, such as cardiac or respiretory errest, a cause on each line. 23e. Pert1. Enter the disease, or consultations shock, or heart feilure. List only one Approximete Intervel Between Onset end Death **Physician** Immediete Ceuse (Finel diseese or condition resulting in death) /Medical Metastatic small Cell carcinoma year **Examiner** Due to (or es e consequença of) Examiner requires that the death certificate be executed attending physician and for usa es the bunel-tran Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): Box 68760 Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown by 8 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed certificata has 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident or Attendette ofter deeth 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funerel Di completaly filled in 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of cartifier May 13, 1998 railes Bennett 1. 1. 025156

P.O. Box 550, Lusby, Md. 20657

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Bennett M.D.

32. Registrer's Signature

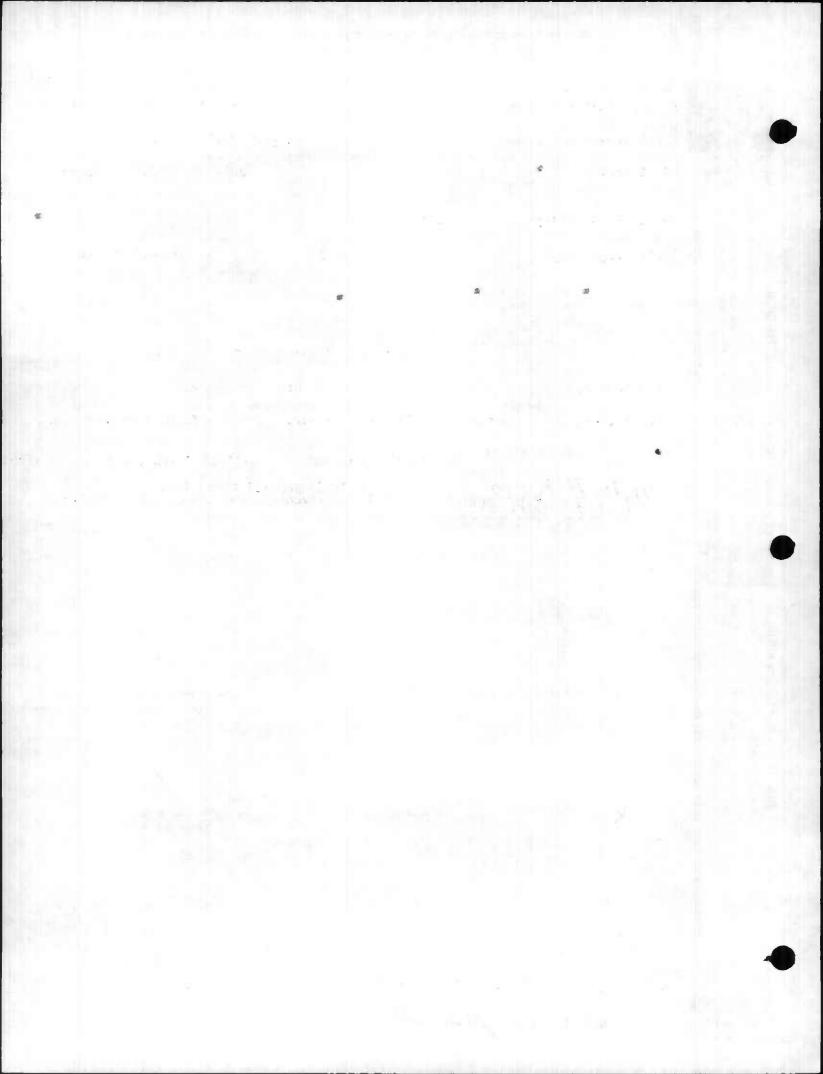
Jalia Davidson Randali

harles 31. Dete filed (Month, Dey, Yeer)

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 13, 1998 4c. County of Death Donald May Ives Reed 10:50 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 23949 Mervell Dean Road Hollywood If Under 24 Hrs. | 8. Da St. Mary's If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 1 X M 2 □ F Months Days Hours Min. Yrs. 280-16-4479 Ohio December 27,1922 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland St. Mary's Hollywood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23949 Mervell Dean Road 20636 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer Maryland State llth 18. Mother's Name (First, Middle, Melden Sumame) 17. Father's Name (First, Middla, Last) Ralph Reed Rice Mabel 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Relationship (Type, Print) Sharon R. Norris/Daughter 45830 BelvoirRd., Great Mills, MD 20634 20b. Placa of Disposition (Nama of cemetary, crematory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 5/18/98 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1□ Yes 20 N 1 ☐ Yes 2 ☐ No 28. Place of Deeth (Check only ona)

and I-transit requires that the death certificate be executed physician ar Division of Vital Records, P.O. Box 68760, 88 attending p signed by the a The law is certificate has director, page 2 or Attending Physician: To this funeral death. rector: A

Direc hin 24 hours aftar the Funeral Dire npletaly filled in b

To the within 2 To the

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification:

Medical

Physician

/Medical

Examiner

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, fre Medical Examinating by notified at once.

25. Wes case referred to medical examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2N No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Spacify) 29e. Certifier

31. Date filed Me

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D06419

29b. Signature and title of certifier

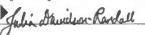
29c. License number 29d. Date signed (Month, Dey, Year)

May 14, 1998

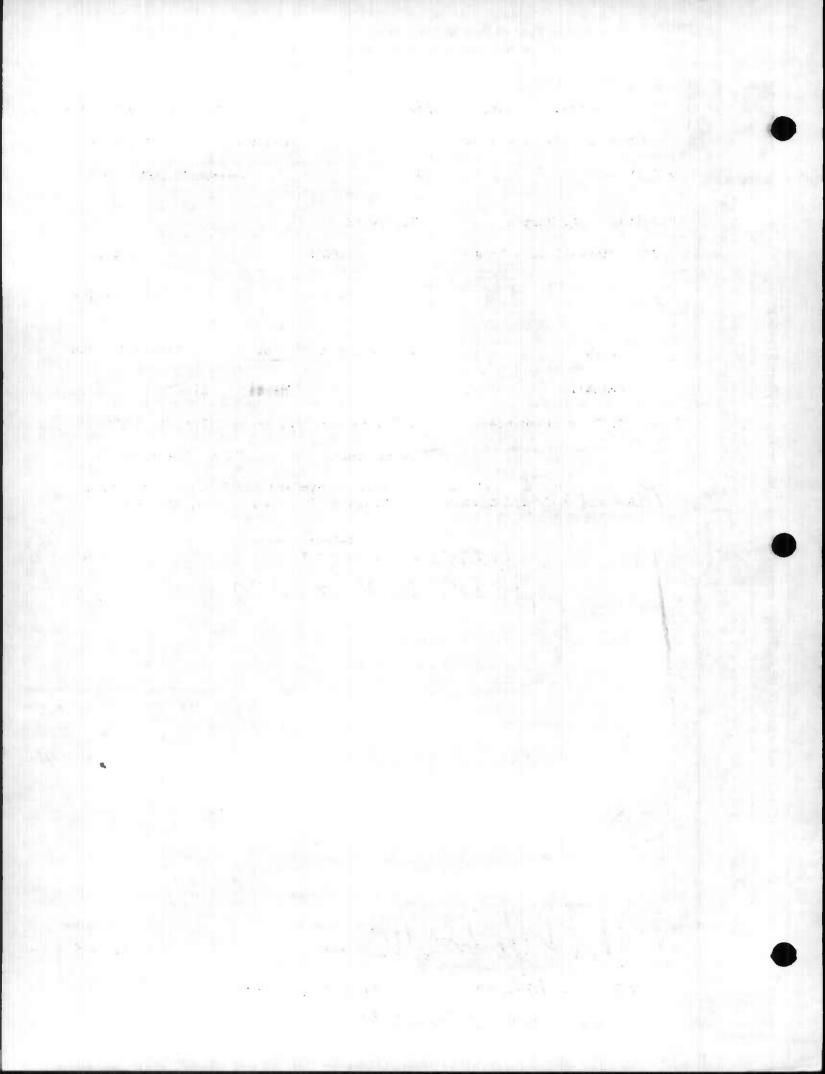
d cause of death (Item 23a) (Type, Print) 30. Name and a

Patrick MD Hollywood, MD 20636 32. Registrar's Signature

State Registrar



DHMH 16 Rev 6/95

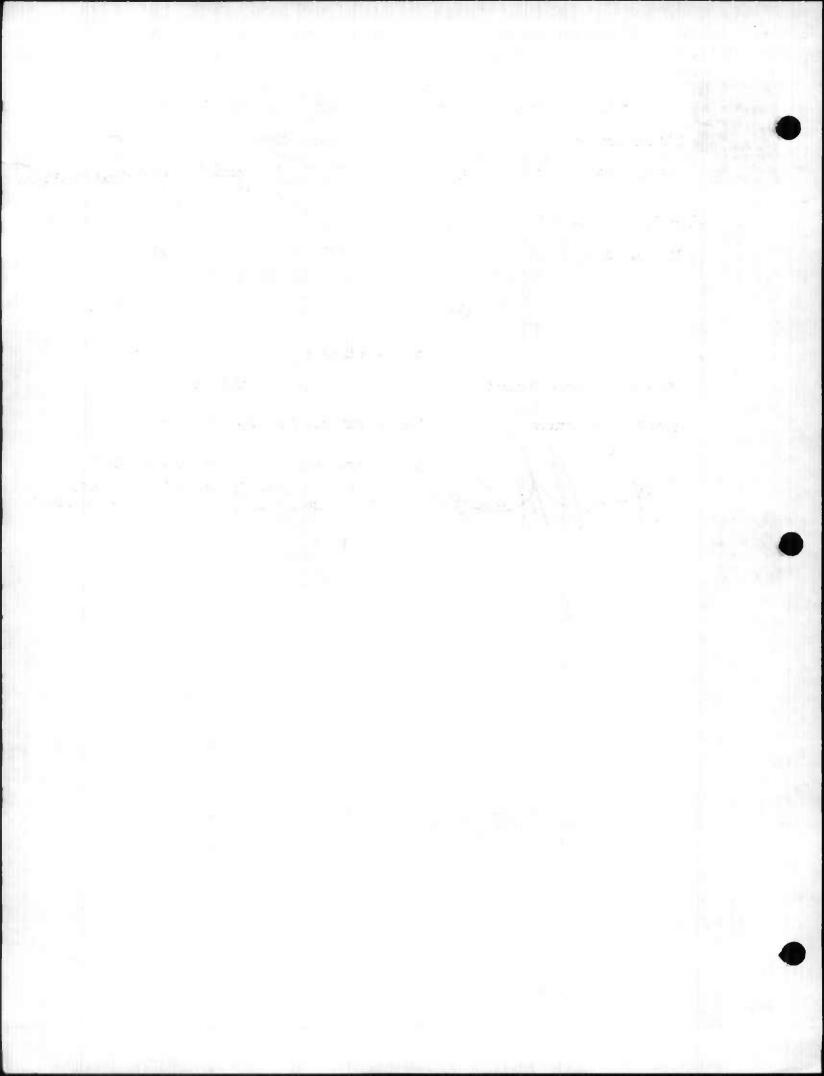


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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						Cer	tificate of	Death		F	Reg. No.		f from a))
	Dhusia		1. Decedent's Nama (First, Middle, La.	st)						2. Dete of Dea	ith	Year	3. Time of De	ath
	Physic /Medi		Charles	Thomas 1	Ransom				ı	May 16,	1998	rear	0805	
5	Exami		4e. Facility Nema (If not Institution, giv. 102 Singer Road	a street and numbar)				4b. City, Town		ation of Deeth		of Death	d	
	Funeral Director		5. Social Security Number 6. S 214-40-9767	M 2□ F	in yrs. last bin 56	thday) Yrs.	If Undar 1 Year Months Days		Min.	B. Dete of Birth (Month, Day March 2	9 ^{ear)} 1942	9. Birthp Coun	elace (Steta or Fo etry) th Caro	
	/land		10e. Stete 10b. County	1	Oc. City, Town	n or Loc	cation					1	0d. Inside City L	imits
	h the Maryland r 28a-f show	Director	Maryland Harfor	rd	Abing	gdor	10f. Zip Code				10g. Citizen of N	Affact Cour	1 ☐ Yes 2 ₫	No
	23a or	eral Di	102 Singer Road				210				USA			
020	filed within 72 hours efter death with the Maryland Hygiene. That than "natural", or items 23s or 28s-f show hit, the Wedical Experient must be notified at	by Funeral	11. Marital Stetus t ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Wes Decedent Ever Armed Forces? Y Yes 2 No If Yes, Give Yeer or Dates: 1	962 – 65	If	Vas Decedent of Yas, specify Cut ☐ Yes 2☐√No	oen, Mexican,	n? (Spec Puerto R	ify Yas or No- ican, etc.)		e - Amaric ck, White, Whi	atc.	
5-0	d within 72 hours piene. r than "netural", the Medical Exe	Completed	15. Decedent's Ed (Specify only highest gre	lucation	1	(Give I	ent's Usuel Occu	during most o	of working	7	16b. Kind of B	usiness/inc	Justry	
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d 2	be filed tal Hygid d other event, ti		17. Fether's Neme (First, Middle, Last)	4	Da	Lauc	ise main		s Name /	First Middle	Maiden Sumen		_	
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Maryland 21215-0020	(1 10 70 00		19e. Informent's Neme/Reletionship (1) Mary Ransom/ Frie				Address (Stree					Steta, Zip	Code)	
ore,	of Health Item 27		20e. Mathod of Disposition				ition (Neme of etory or other pla			Dete	20c. Location -	City or To	wn, State	
im	Pege ment ant: If ury or		1 ☐ Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Society)	Premogan from Some			Service		5	-18-98	Towson	, Mar	yland	
Baltimore,	permit. Peges 1 and Depertment of Health Important: if Item 27 any Injury or other tr		21. Signtification of Funeral Service Loan		1	1	Name end Addr Howard K	. McCa	mas	III Fur	neral H	ome,	P.A.	00
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	Examiner		diseese or condition resulting in death)	-	CVD e to (or es e d	consequ	uence of):					1		
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oʻ.	execute an end rial-tran	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Inji ry	Du Du	e to (or es e c	consequ	ience of):							
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Rec	S C	du										of c	death?	
a		e Co	25. Wes case referred to medical						. = - 1.11	1 Y	A	1	Yas Ž No	
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of	문 문 등		27. Manner of Deeth	28e. Date of Injury	28b. T	ima of	28c. Inju	4 LI NUIS			ence 6 □Oth ow injury occur		"	
Ö	Attending or deeth.	atlo	1 Naturel 5 Pending 2 Accident Investigation	(Month, Dey Y	ae <i>r)</i> In	njury N		ork?]Yes 2.5√ No	0	NA				
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	To the Hospital or Attending within 24 hours efter deeth. To the Funeral Director: After completely filled in by the fune	edlcai	29e. Certifier (Check only one) 1☐ Certifying Phy 2☐ Medical Exam	Iner: On the best of m lner: On the bests of ex end manner steted	amination end	, deeth 1/or Inve	occurred et the ti estigetion, in my	me, dete and popinion, deeth	plece, en occurred	d due to the c	euse(s) end ma	inner es st and due to	eted. the cause(s)	
	To t	Σ	29b. Signature and title of certifler	Paral			29c. Licen:	se number		2	9d. Dete signa	d (Month, I	Dey, Yeer)	
			annu	1 1000		ME		OCME			May 1	6th	1998	
0	7+1		30. Name and address of person who c							1011	10 0=	0		
	Sta	- 6	G.S. Prabhu M.D. 31. Date filed (Month, Dey, Year)	32. Registrer's			e Bel A	ir MD	2:	1014 4	10-87	9 - 651	54	
	Registr	GI .	MAY 1 9 19	JO JAMA	and the	THE PARTY	14							



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month APRTI.

	Physician
)	/Medical Examiner

Fune Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental thygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

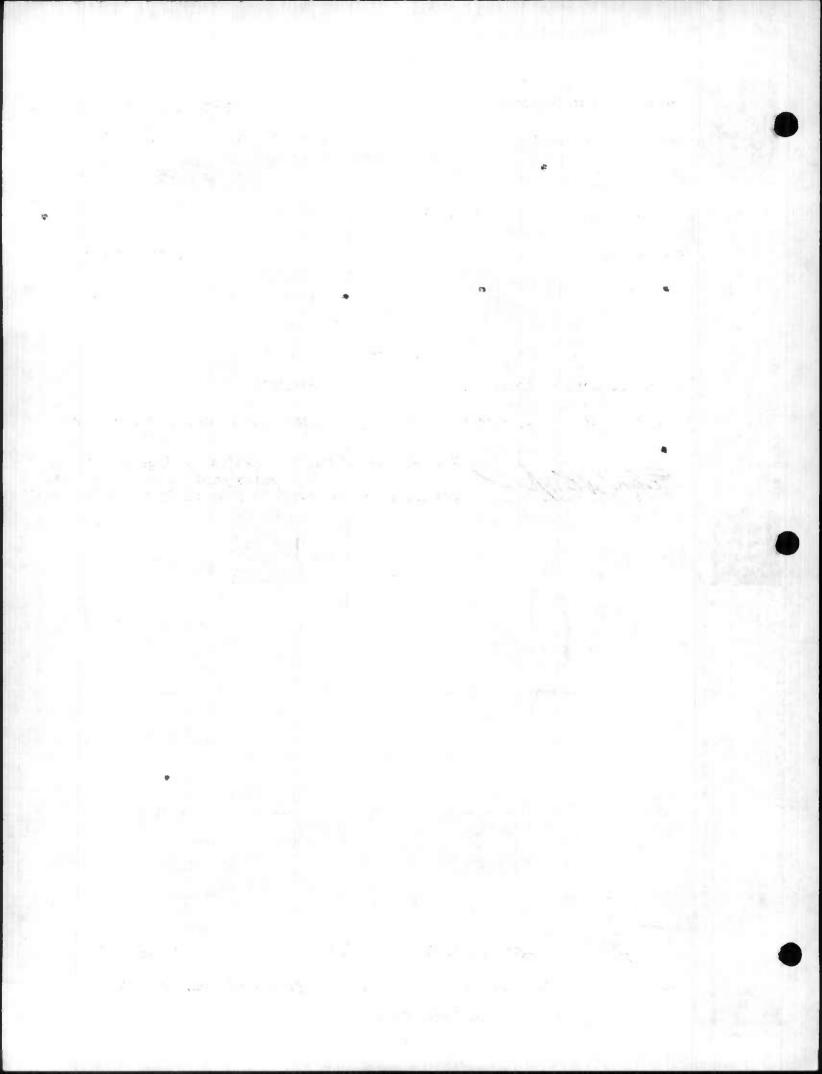
Baltimore, Maryland 21215-0020

Physicia /Medic Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit SCRIBER of JAMES FRANKIIN Box 68760,

S.C. Olly Towns (Inch statistics, one stated and number) S.C. Olly Towns of Location of Deem S.C. Olly Towns of Location of Deem S.C. Olly Towns of Location of Deem S.C. Olly Towns of Location of Deem S.C. Olly Towns of Location of Location S.C. Olly Towns of Location of Location S.C. Olly Towns of Location S.C. Olly Towns of Location S.C. Olly Towns of Location Deep S.C. Olly Towns of Locati	09:39	1998 09	2.5 J	APRIL					UI.	or ther,		aunt.	mes Fr	Da	cal
5. Social Security Number 216—78—5848 1									imber)						
Solid Selection Continue Co	ce (Stete or Fe	9. Birthplece (Country) Marylar	Year)	8. Dete of Birth (Month, Dey,	er 24 Hrs. s Min.	r If Unde				Sex	6.	Number 848	clal Security 16-78-5	5. Soc 216	
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. In mediate Cause (Fine) shock, or heert feiture. List only one cause on each line. Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause (and the consequence of): 1 Yea 2 No 3 Probable of the consequence of): 24a Wes an eutopsy performed? 25c. Wes case referred to medical agaminer? 25c. Wes case referred to medical agaminer? 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the consequence of): 25d. Magrier of Death The patient of the patient of the patient of the patient of the patient of the patient of the patient	d. Inside City L	10d. In					cation	City, Town	100			T		-	
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11 Marries Better 12 Wes Decedent Ever in U.S. 13 Wes Decedent of Hispanic Origin? (Specify Yes or No. 14 Reps Americal Block, White, set Specify 15 Never Married 20 Married 10 Wes Original Block	y?	Whet Country?	2. Citizen of V	10			10f. Zip Code					mber	Street end Nu	10e. S	irec
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30. Neme and eddress of person who completed a use of deeth (Item 23e) (Type, Print) William D. Boyd II, M.D., 25365 Point Lookout Rd, Leonardtown, MD 20650	8	75-98	7-0		J		-		100						-



Physic /Med Exam

Funera

Directo permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examinal must be notified and once.

Baltimore, Maryland 21215-0020 Physician /Medical Examine

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this cartificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

JAMES LOUIS STEWART

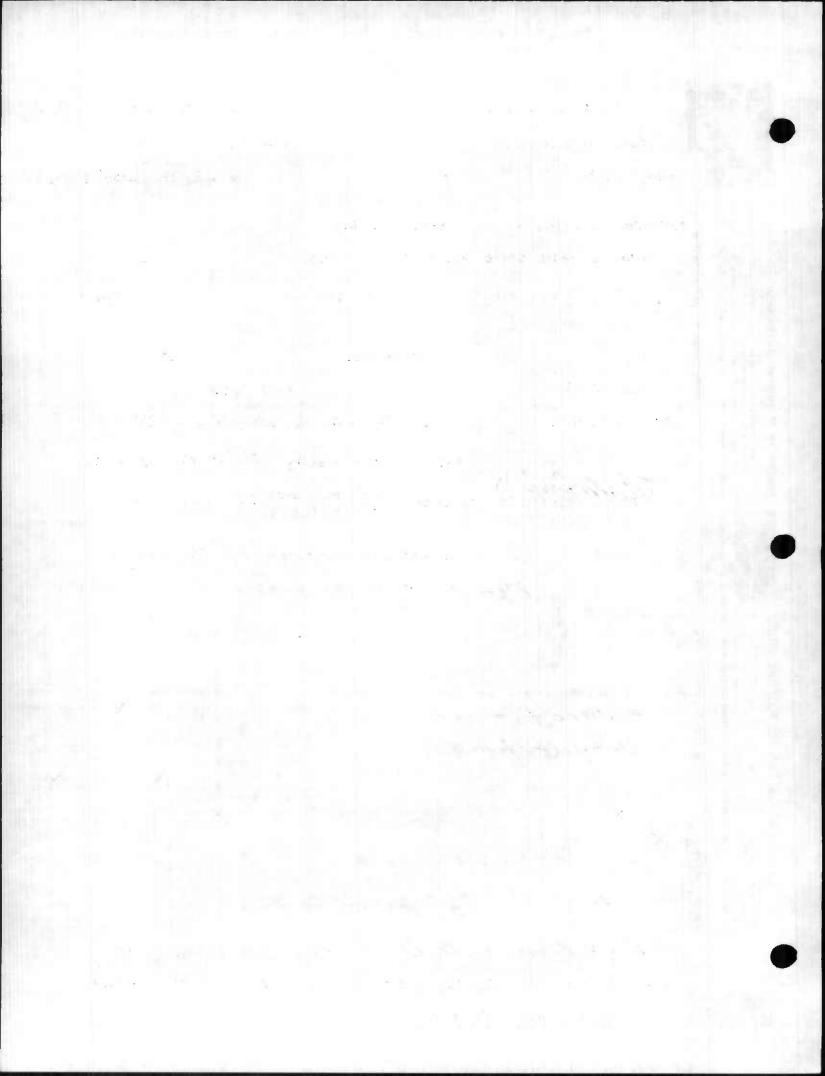
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ian	James Louis Stewart, Sr.						Month April	Dey	Year 998	5:20 AM
icai iner	4a. Facility Name (II not institution, give street and number)				4b. City, Tow	_	ation of Deeth			
11161	St. Mary's Hospital				Leona	rdto	wn		Mai	
П	5. Social Security Number 6. Sex 7. Aga (In yrs. las	t birthday)	If Under Months	1 Yeer Davs	If Under 24		8. Date of Birt	h Yearl	9. Birl	thplaca (State or Foreign
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	Usual Residence of Decedent									
_	10a. State 10b. County 10c. City, 1 Maryland St. Mary's L	ovev:								10d. Inside City Limits
Director		ovev.								
Dire	10e. Street and Number		10f. Zip					10g. Citizen of		ountry?
rai	27003 Point Lookout Road		20	656				U.S.A	L +	
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Be	James Louis Stewart					ath1			·	
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	19e. Informant'a Name/Relationshlp (Type, Print) M. LaVerne Stewart/Spouse		-					or, City or Town		
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	Michael Lever Hardener		_					Maryla		
	23a. Part1. Enter the disease, or complications that caused the beath. shock, or heart failure. List only ona causa on each line.	Do not an	ar the mode	of dyi	ng, such as ca	ardiac or	respiratory e	rest,		Approximate Interval Between
										Onsat and Death
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l.	resulting in death) Dua to (or a							0		
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каш	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	s a consac	quenca of):							110000003
E	Cause. Enter Underlying Cause (Disasse or injury that initiated events									76
dic	that initiated events resulting in death) Lest Dua to (or as	a conseq	uence of):							
an/Medical Examiner	d									
Completed by Physic	Part II. Other significent conditions contributing to death but not resulting	ng in the u	nderlying ca	ausa gir	en in Part I.		23b. Dld	tobacco uae co	ntribute	to the cause of death?
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by	Provident Commission	-		,,,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Tour	Man automorphism times
etec	Prograte Carasiona.						24e. Was perio	en eutopsy med?		Were eutopsy findings available prior to completion of cause
npldu	Respiration feciliare -		_							of death?
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Be	25. Was case rafarrad to medical examinar?			Lau		of Deeth	(Check only o	na)		
10		VOutpatier		^		-		dence 6 □Ott		ocify)
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Daniel Bicknell Sweeney, Sr. 19, /Medical May 1998 09:50 AM 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F Director Yrs 598-12-4072 81 April 20, 1917 Maryland Usual Residence of Decedent the Maryland 10a Slale 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f sho Director 1 Yes 2 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 20636 U.S.A. 24632 Hollywood Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Dacedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yas 2 💢 No If Yas, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No by Specify: 3 Widowed 4 Divorced White I Hygiene. other than "nature ent, the Weulcal Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry St. Mary's County Elementary/Secondery (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filed witness of Health and Mental Hygier trant: If item 27 is marked other the lury or other traumatic event, the 8th School Bus Driver Public Schools Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be May Eulalia Daniel Webster Sweeney 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24632 Hollywood Road, Hollywood, MD 20636 Mavis Sweeney/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State Department of important: If any Injury or Hollywood Church of the 4 ☐ Donation 5 ☐ Other (Specify) Nazarene Cemetery 22. Nama and Address of Facility 5/22/98 Hollywood, Maryland 21. Signature of Funeral Service Licanse Mattingley-Gardiner Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

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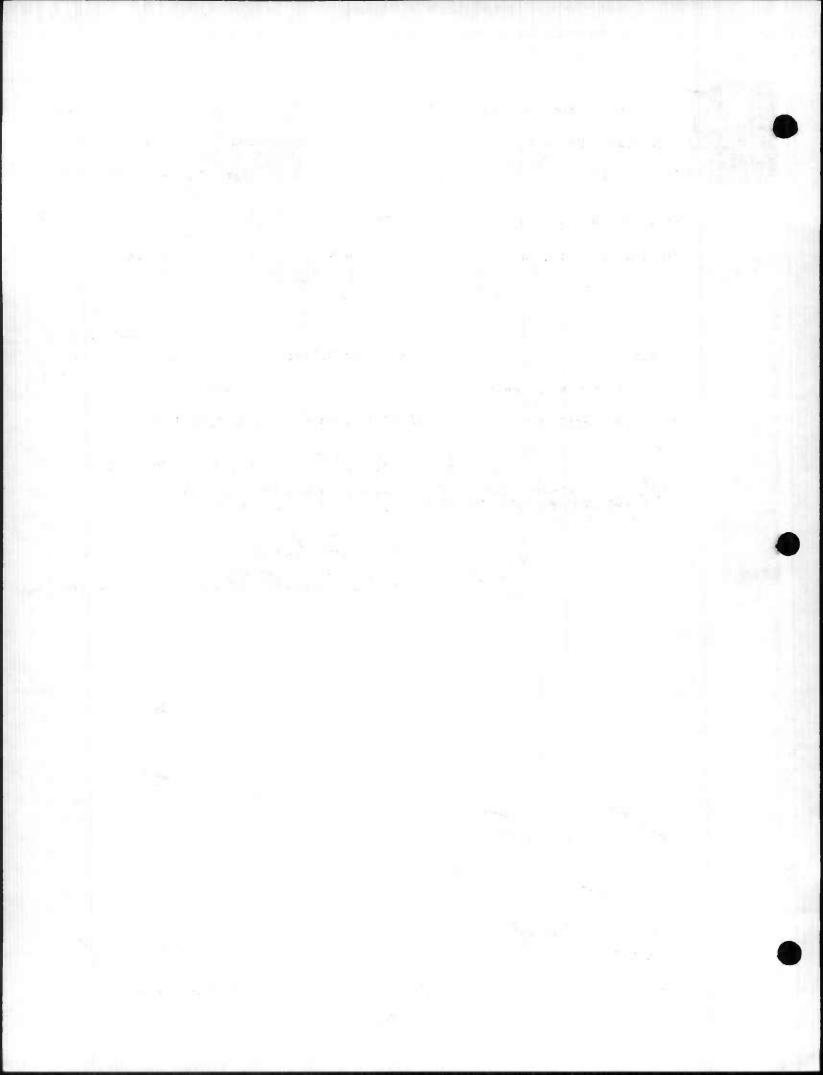
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Approximately 20650 Approximete Intarval Between Onsel and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ulure Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Ceuse (Disease or injury that initiated events resulting in death) Last pur Due to (or as a consequenca of) SWEENEY, DANIEL BICKNELL SR Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) 60 ata has been signed by the attendin page 2 should be detached for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Wes an eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? 2800 this certificata 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica director. 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 hipatieni 2 ER/Outpatient 3 DOA illed in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the causa(s) and manner as stated. Medical 29a, Certifier completaly (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated. 29b. Signature and title of cegiffe 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who comcause of death (flem 23a) (Type, Print) David C. Allen, M.D. 2050 Wildewood Ctr. CALIFORNIA, MD20619 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Jalia Dhuilean Randall Registrar

DHMH 16 Ray 6/95



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State of Maryland / Department of Health and Mental Hygiene

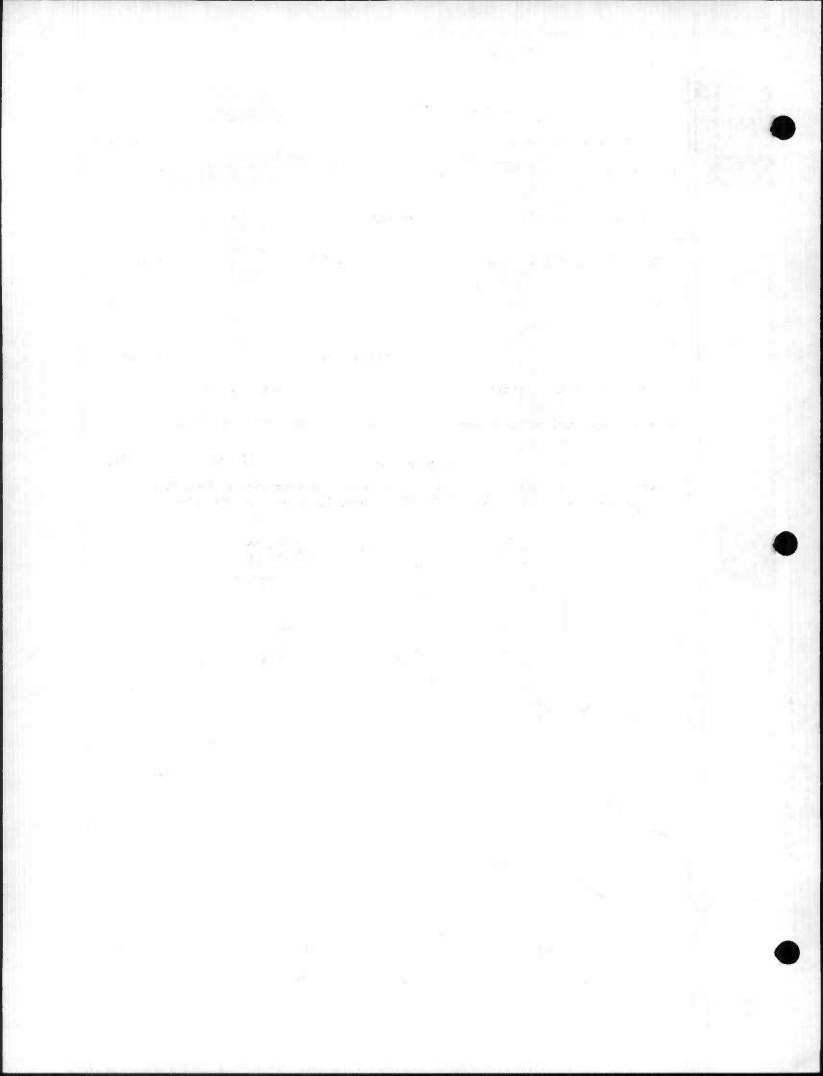
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Voor Frances Alberta Smith May 1998 24 /Medical 4:40 AM 4b. City, Town, or Location of Deeth 4e. Fecliity Name (If not institution, give street end number) 4c. County of Deeth **Examiner** St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Days Yrs. 219-80-1326 65 Director January 31, 1933 Maryland Usuel Residence of Deceden with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic avent, the Medical Examinal must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Callaway 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23, any Injury or other traumatic avent, the Medical Exercisinal naturals. Funeral 20481 Piney Point Road 20620 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American indian, Biack, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specity: Specify: þ Black 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) llth Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thomas William Jordan Mary F. Hill 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) P.O.Box 75, Callaway, MD 20620 Patricia Ann Smith/Daughter 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holy Face Cemetery 5/28/98 Great Mills, MD 21. Signature of Funerel Service Licensee 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. nolune P.O.Box 270, Leonardtown, MD Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete nterval Retween Onset and Death **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner bunial-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medicai 12 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? this certificate has 1 Yes 2 No t ☐ Yes 2 ☐ No I or Attanding Physician: after death. Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Brigationt 2 ER/Outpatient 3 DOA funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled is 1 De Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as steled.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner steled. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) May 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)
DR. YOUNGSIK MOON P.O. BOX 37 HOLLYWOOD, MD 20636

State Registrar

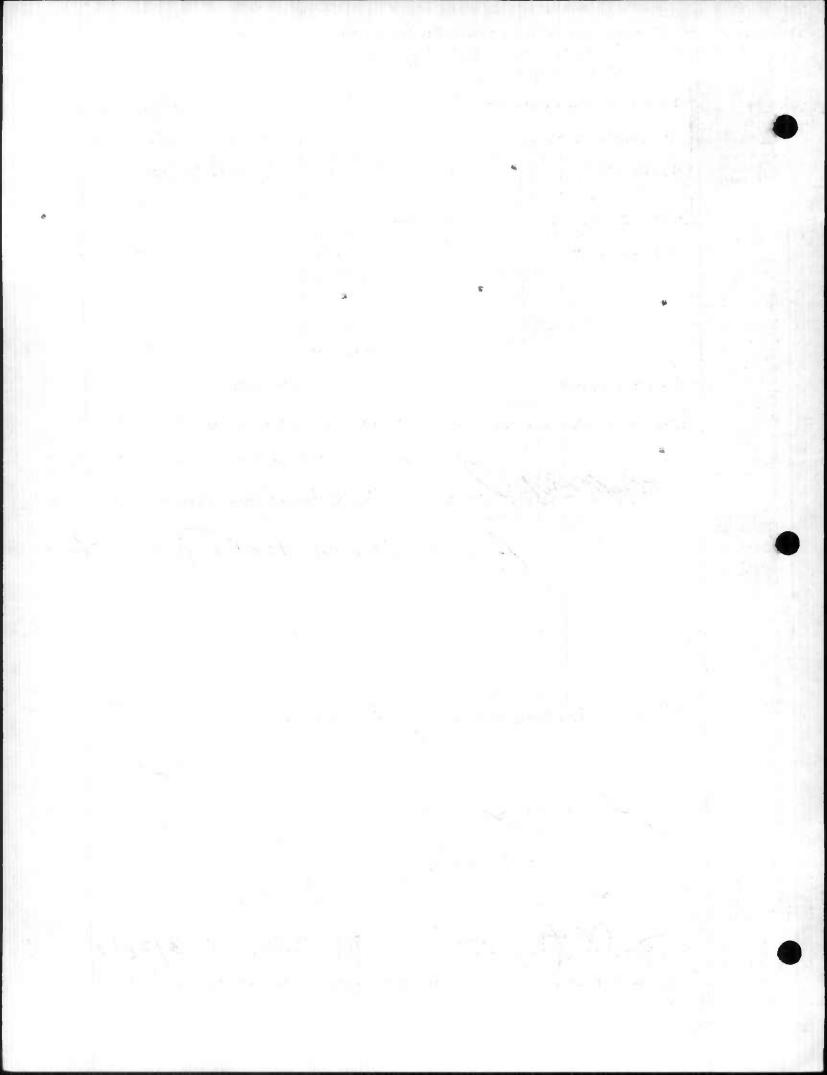
31. Dete filed (Month, Day, Year) 32 Registrer's Signature MAY 26 1998

Alder Smith



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	Physic	20	1. Decedent's Name (First, Middle, La				2. Date of De	Day	Year	3. Time of Death											
Physician /Medical Examiner			Marguerite Ruth						May 28			2:59 PM									
			4a. Facility Name (If not institution, giv					4b. City, Town, or													
-			St. Mary's Hospi 5. Social Security Number 6.5		e (In yrs. last b	inth of a cit	If Under 1 Ya	Leonard			Mary'										
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ith the A or 28a-	or 28a	Funeral Director	10e. Street and Number 24494 FWD Drive	,		,	10f. Zip Cod			10g. Citizan of V											
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Maryla d 2 should I th end Meni 7 le marke traumatic			19a. informant's Neme/Relationship (Type, Print)	19	b. Mailing	Address (Str	eet and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip	Code)									
	CHNL		William C. Schaef	er, Sr.				2, Hollywo													
more	ages 1 e ent of Hez nt: If item y or othe		20a. Method of Disposition 1 ■ Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specification 1)				ition (Name of atory or other p Memori	omce) al Gardens	Date 5 6-1-98	20c. Location -											
Baltimore,	permit. Pages Depertment of H Important: If the eny Injury or of		21. Signatura et uneral Service Lote	200/		22. H	Name and Ad	drass of Facility	al Home.	P.A.	-										
	_			nefield, Ji			22955 H	lollywood l	Road, Le	onardto	wn, M	D 20650 Approximate									
	Physician /Medicai Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinated shock, or heart failure. List only one cause on each line. immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of):							$\neg \cap$	Son .	Onset and Deeth									
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	0 0 0	by Physician/N	Pert ii. Other significant conditions o	ontributing to death b	ut not resulting	In the unc	derlying cause	given in Part i.	23b. Did	tobacco use co	ntributa to	the cause of death?									
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Division or Attending	after des Directo	ertific	ertific	Certification:	ertifica	3 Sulcida 6 Could not be determined	28e. Piaca of Inj building, et	ury - At home, f c. (Specify)	farm, stree	et, factory, offic	ca	28f. Location (City or To	Street and Numb wn, State)	er or Rura	l Route Number,						
_	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best ninar: On the besis of end manner st	examination a	ge, death o	occurred at the estigation, in m	e time, date and place by opinion, deeth occu	, end due to the rred et the time,	cause(s) and ma dete end place,	anner as at and due to	ated. the cause(s)									
	To the within To the	Me	29b. Signature and title on the second	7 10			29c. Lice	ense number		29d. Date signe	d (Month, I	Day, Year)									
			30. Neme end address of person who							-/-	11.1.)									
			David C. Allen,					, Californ	ia, Mar	yland 20)619										
	Sta Registr		31. Date filed (Month, Day, Year) NAY 29	32. Registr	ar's Signeture	u-Raro	Lall														
511				U																	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2 Pate of Deeth FRANCIS LEE SIMMS IAY 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Fallston General Hospital Fallston Harford If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) Dec. 4, 1935 5. Sociel Security Number If Under 1 Year Birthplece (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 1 → M 2 □ F Deys Mary Land 220-32-7520 62 Yrs. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Maryland 1 ☐ Yes 2X No Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 508 Sugar Hill Road 21085 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Construction Heavy Equipment Operator 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Isaac Francis Simms Virginia Lee Edwards 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Anna L. Simms/Wife 508 Sugar Hill Road, Joppa, MD 21085 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Strain 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Darlington Cemetery 5-23-98 Darlington, MD 21. Signeture of Jumeral Servica Licansee 22. Neme end Address of Fecility Howard K. McComas III Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Apparent feiture. List only one phase on each line. pproximete Onset end Deeth SEPSIS Immediate Ceuse (Finel diseese or condition resulting in deeth) HEPATIC ENCEPHALO PATHY ALCOHOLISM Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacce use contributs to the cause of death? 200No 3 Probably 4 Unknown PULMONARY 1 Yes OBSTRUCTIVE 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medicai Examiner

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items 23a

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Departing 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than

the

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest

25. Wes case referred to medical examiner?

1 Yes

Menner of Deeth

Naturel 2 Accident

3 Sulcide

29e. Certifier

4 - Homicide

HYPERTENSION

Inpatient

1 ☐ Yes 2 ☐ No

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7 81	ro i	na Hon		Doo	Idonos	

Other: 4 Nursing Home 6 ☐Other (Specify)

2 ER/Outpetient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Tes 2 No

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

Madical Examiner: On the bests of examinetion and/or investigetion, in my opinion, death occurred et the time, dete end pleca, and due to the cause(s) end menner steted.

29c. License number H41069 29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. Stanley Kman 1308 Business Center Way #102 Edgewood, MD 21040 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

MAY 22 1998

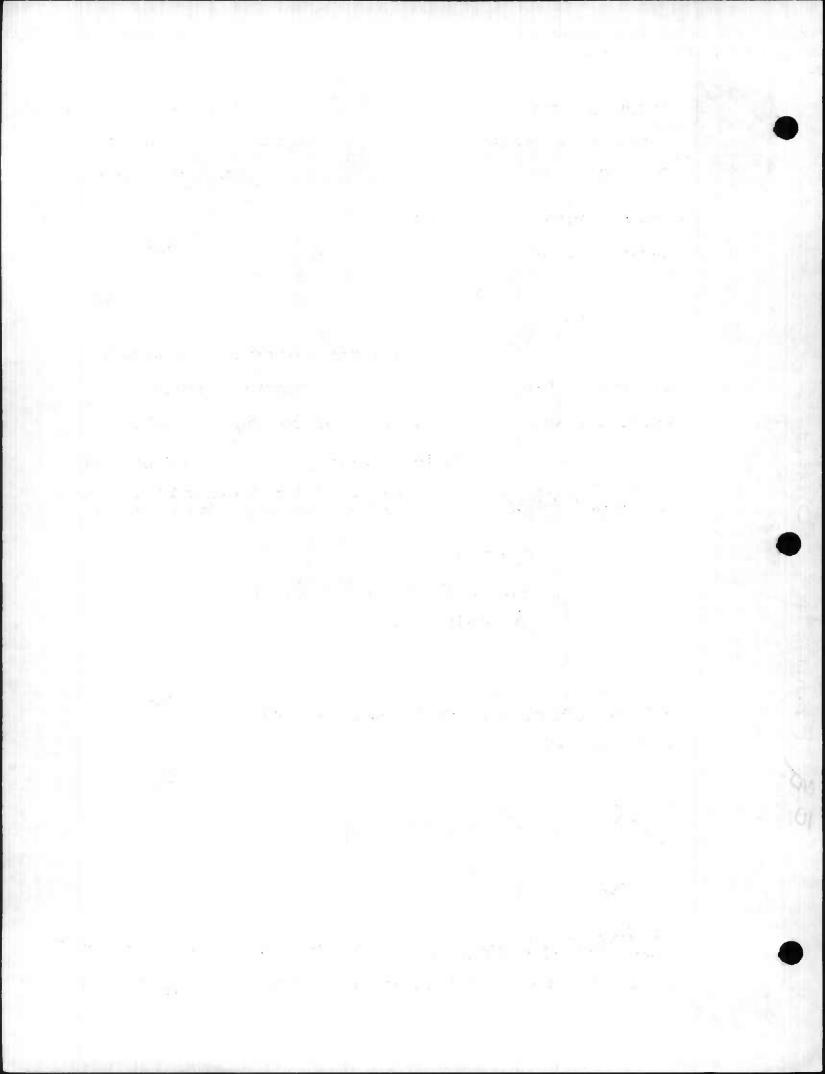
5 Pending Investigation

6 Could not be determined

Din Shudler Ranfall

To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day Year **Physician** Rosina Elaine Viar 2255 P Reese 17, 1998 ath 4c. County of Death MAY /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2217 WHITEFORD HARFORD Whiteford If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Deys 1 M 2 XF Director 217-88-4473 Sept. 21, 1962 Maryland 35 Usual Residence of Deceden the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show trsumetic svent, its Madical Examiner mast be notified at 1 Yes 2 No Directo Pennsylvania York Delta 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 301 Main Street 17314 USA Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Stelus 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or he any mury or other traumatic avent, Ita Marion Inanian 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White λq 3 ☐ Widowed 4 ☐ Divorced Year or Deles: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mail Carrier U.S. Postal Service 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Rosina Marie Berger Robert Edward Reese 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Anthony Jacob Viar/ Husband 301 Main Street, Delta, PA 17314 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burlal 2 Cremation 4 Donetion 5 Other Bel Air Memorial Gardens 5-21-98 Bel Air, Maryland 21. Signalus Funeral Ser 22. Name and Address of Fecility Howard K. McComas Funeral Home, P.A. 1317 Cokesbury RD, Abingdon, Maryland 21009

Do not enter the mode of dying, such as cardiac or respiratory errest.

Approximate Part I. Enter the constant shock, or heart failure. Approximate interval Between Onser end Death **Physician** Multiple Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physicien end the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 88 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed certificate has pege 2 1 Yes 2 □ No 1 TYes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatien1 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 28a. Dete of Injury (Month, Day Year) 5—(7—98 28d. Describe how injury occurred Molurcycle 27. Menner of Death 28b. Time of injury 22 SO M 28c. injury at Work? Certification: 1 Naturat 5 Pending investigation operator - auto 1 Yes 2 PNo collision 2 Pl Accident

certificate be executed Box 68760 P.O. Division of Vital Records, After this funeral il or Attanding s efter death. il Director: Aft 3 Hospital 24 hours To the within 2

Baltimore, Maryland 21215-0020

29a. Certifier (Check only one) 29b. Signature end fitte of cartifier

Medical

3 ☐ Sulcide

4 Homicide

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number O.C.M.E.

to Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) and menner es steted.

29d. Date signed (Month, Dey, Year) MAY 18, 1998

28f. Location (Street and Number or Rural Route Number, City or Town, State)

whiteford

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

row ler 31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

Registrar

MAY 1 9 1998

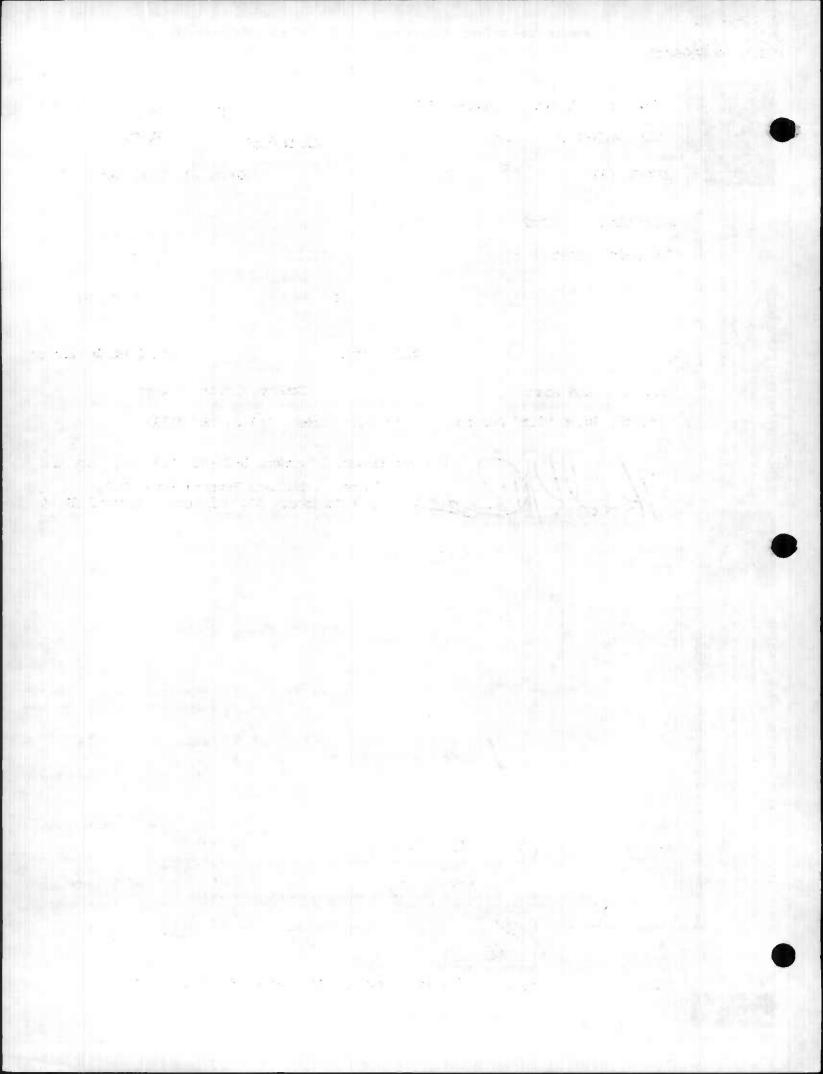
6 Could not be determined



28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Roudway

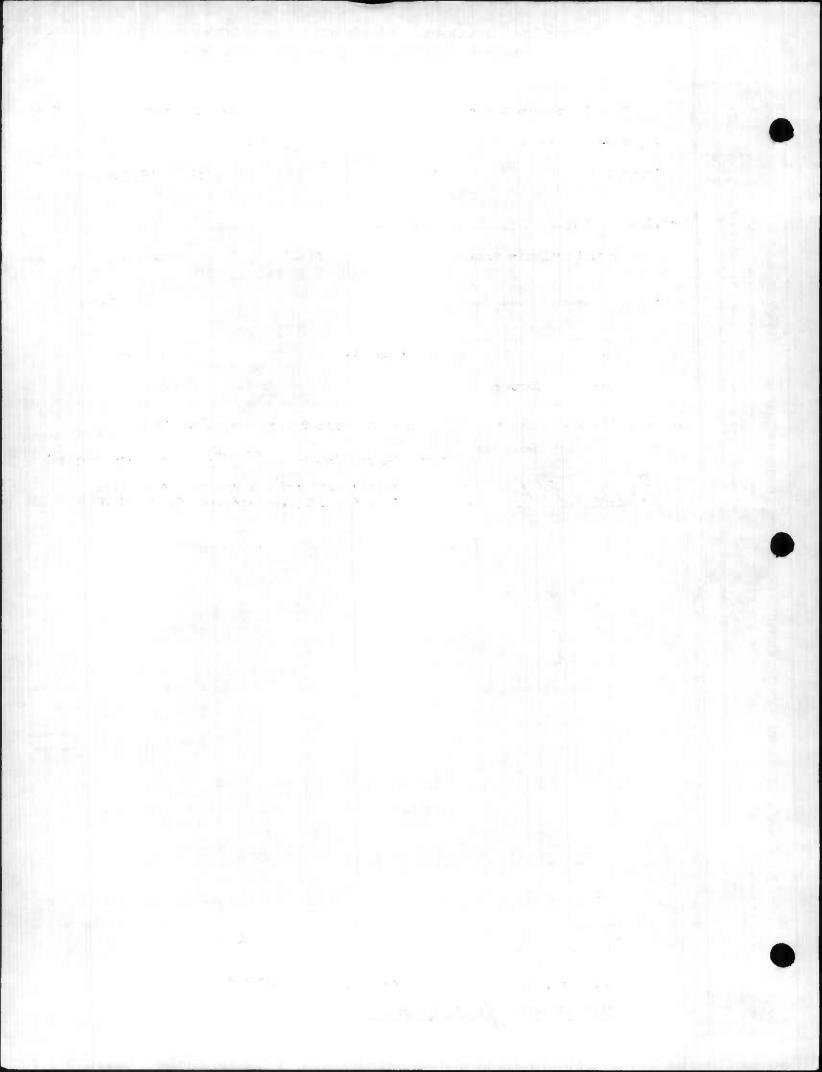
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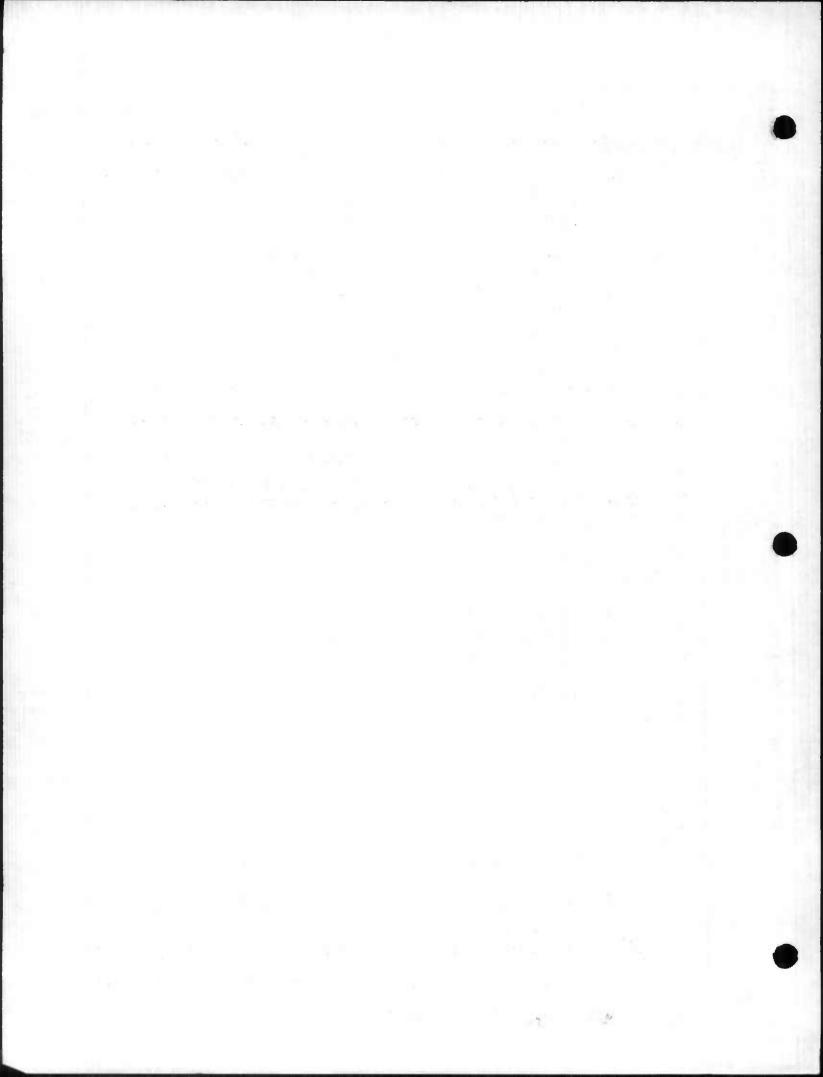
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	pu a	-	suel Restdence of a. State	Decedent 10b. County			10	c. City, Tow	n or Loca	ation						_	10	d. Inside City	Limits
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentel Hygiene. Important: If ferm 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Euneral Director.	2	1. Signature of Fu	neral Servica	License	98 /	1 -			Name and A				Funer	al Hor	no I	ο Δ		
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	To the Hospital or Attending Physician: The is within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Madical Certification: To Re Com	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the control of the contr																	
	Nithin Fo the compl		b. Signature and	fitle of certifie	ır					29c. L	icens	e number			29d. Date	signed (i	Month, I	Day, Year)	
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		30	. Name end eddr	ess of person	who co	mpteted caus	se of death	(Item 23a)	(Type P	nint)					->	-		CJ	
				D. Sha						own,	Mar	rvlan	d 20	650					
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er death with the Marytac itsers 23s or 25s-f show the must be notified at	ai Director	10e. Street and Number 7200 Third Avenue	9	(a)	10f. 2	Zip Code	21784		10g. Citizen of V					
当 大百	by Funeral	11. Maritel Stelus 1 □ Never Married 2 □ Merried 3 ☒ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 1 N H Yes, Give Yeer or Detes:			edent of Hoecify Cube	lispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Ricen, etc.)	14. Rac Bied Specify	ce - American Inc ck, While, elc.				
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mit. Pages partment of i portant: if the injury or or	2	1 Buriel 2 □ Cremelion 3 □ I 4 □ Donetion 5 □ Other (Specify, 21. Signature of Funerel Service Licens	. 5/18/	5/18/98 Paradise, PA										
Deg Imp		22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410) – 795–1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, interval Barbara Onset and Death Onset and Death												
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Pseu	Dua to (or es a co	as	brow				Onse	non H			
Jeath certificate be executed attending physician and dor use as the burial-transit	an/Medical Examiner	Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaase or injury that initieted evants resulting in death) Last	b. Vas c	Dua to (or es e co	leme nsequence o	nhie				7	urs			
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E as a	Be	25. Was case refarred to medical exeminer?	1			la.		1 □ eth (Check only o	William Co.	1 □ Yes	2□ No			
Ang Phys h. After this funaral di	Certification: To	1 Yes 25 No 27. Menner of Death 1 Neture 5 Pending Investigation 3 Suicide 6 Could not be	lospitel: 1 ☐ Inpallel 28a. Dete of Injur (Month, Day	y Year) 28b. Tir		4 pat Nursing I		how injury occur	red					
To the Hospital or Attend within 24 hours after death To the Funeral Directors completely filled in by the		4 Homicide determined	building, etc	f my knowledge (laath occurre	d at the tir	ne, data and piece	City or To	caucale) and me	non ec eleted				
To the h within 24 To the F complete	and menner steted. 29b. Signature end title of certifier 29c. License number								29d. Dete signe		Year)			
		30. Nama end eddress of person who co	empleted causa of da	ath (Item 23e) (T			4406 Elde			21784				
St: Regist	ate rar	31. Dete filled (Month, Day, Year)	32. Registre	r's Signeture										



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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month May 0620 1998 Lucille Alice Wilson /Medical 4e. Fecility Neme (If not institution, give street end number, 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Oct. 30 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 □ M 2 KF Months Deys Hours 213-36-8310 Yrs Director 82 1915 New York Usual Residence of Decedent 10a. Slele 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. other than "natural", or items 23a or 28a-f show went, the Medical Examination must be notified at 1 Tyes 2 TXNo Director MD Harford Aberdeen 10e Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 1812 Park Beach Drive 21001 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours aftar cand of Jeath and Mertal Hydjona.

nt: If fem 27 is marked other than "natural", or fer iny or other traumatic avent, Illia Medical Examina 1X Yes 2 No WWII
If Yes, Give
Yeer or Deles: 11 Yrs 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Nurse U.S. Army 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be George Wilson Dorothy Gates P 19e. Informent's Name/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) P.O. Box 172, Abingdon, MD Jill Mussen (Cousin) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete permit. Pages Department of Important: If it any injury or o © Burlal 2 ☐ Cremetion 3 ☑Removel from State Black River Cemetery 5/22 Black River, NY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fune Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Pent1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner ician and buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest physician the burie Box 68760, been signed by the attendin should be datached for use P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Vital Records, À 24b. Were autopsy findings evallable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 XNo Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ot 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 1 Waturel 5 Pending 1 Tyes 2 No death. investigation 2 Accident ofter death Director: 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours efter To the Funeral Direct complately filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifies 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
CHALLES ECUTE TU 219W. BELLO HUE. ABECIDEEN, MO 31. Dete filed (Month, Dey, Year) Registrar's Signeture State MAY 1 9 1998 Registrar

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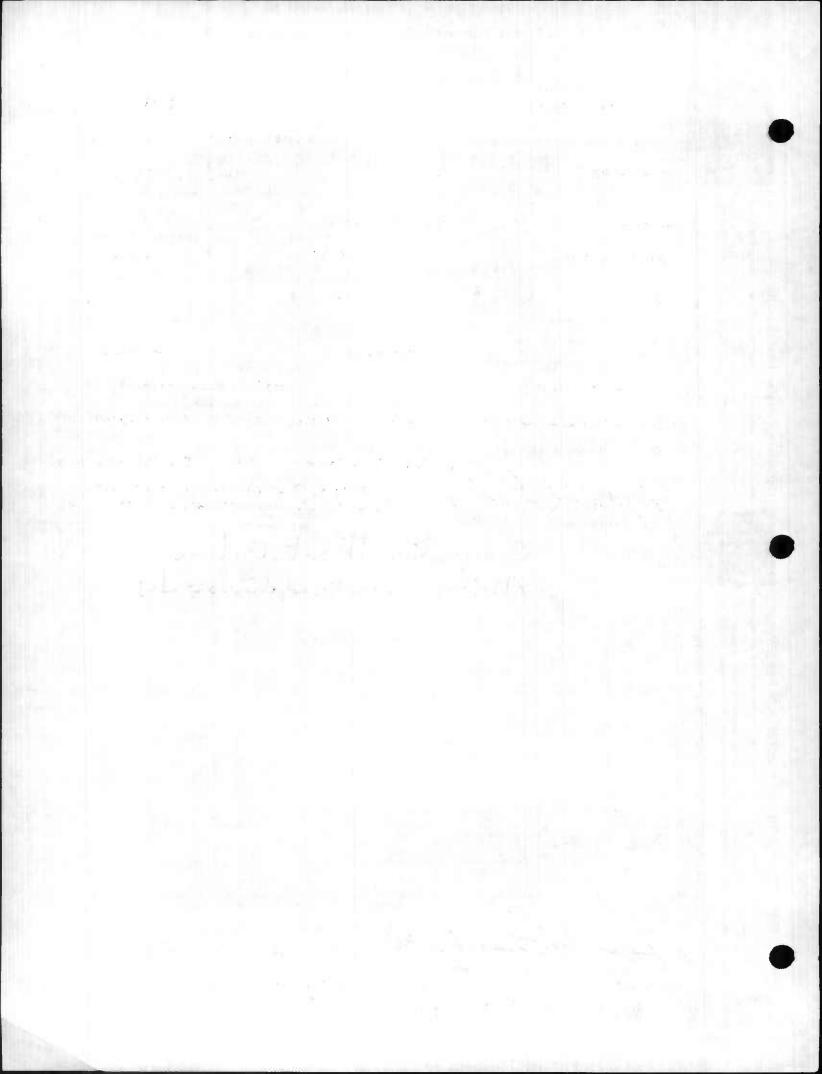
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State of Maryla

and / Department of Health and Mental H	lygiene	9	R	1	73	3 1	
Certificate of Death	Reg. No.	-	0		1	2 1	

			Certifi	icate of	Death	F	leg. No.	1/311
6 1 1 1	Decedent's Nama (First, Middle, Last)		1.1-1			2. Date of Dea	Day	3. Time of Deeth
Physician /Medical	Susie Young			Month May 3	, 1998 `	12:12 AM		
Examiner	4a Facility Name (If not Institution, giva st	reet and number)			4b. City, Town, or Lo		4c. County of	
45.	46407 Sue Drive				Lexington		St. M	ary's
Funeral Director	5. Social Security Number 6. Sex 1 1 1 1	7. Age (In yrs. 96	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April	Year)	9. Birthplace (State or Foreign Country) Maryland
2 >	Usual Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or Location	200				10d. Insida City Limits
e Maryle	Maryland St. Mary		exingtor					1 ☐ Yas 2 💢 No
or 28	10e. Street and Number		1	Of. Zip Code			0g. Citizen of Wh	nat Country?
th with wind the wind	46407 Sue Drive			2065	3	1	U.S.	Α.
Maryland 21215-0020 d 2 should be filed within 72 hours effer death with the Maryland th and Mentel Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, it's Marieral Examiner manable notified at To Be Completed by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas:		Decedant of H s, specify Cubo Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yas or No- Rican, atc.)	14. Raca Biack, Specify:	- Amarican Indian, Whita, etc. Black
2 ho	15. Decedent's Educe	ition	16e. Decedent'	s Usual Occup	eation		16b. Kind of Bus	iness/Industry
Maryland 21215-0020 td 2 should be filed within 72 hours elt th and Mantel Hygiene. 77 is marked other than "natural", or traumatic event, in a Madical Exam. To Be Completed by F	(Specify only highest grade	College (1-4or 5+)	Homema		during most of work d)	ing	Own H	ome
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should ind Mening Menin	19a. Informant's Name/Relationship (Type		19b. Mailing A	ddress (Street	and Number or Run			
Mar nd 2 sho aith and 27 is m r traum	Alice E. Countiss/I							yland 20653
Te, N 1 end 1 Health Em 27 i	20a. Method of Disposition	20b. P	Place of Disposition	n (Nama of	1	Date		City or Town, Stata
Baltimore, Jemes 1 en	1 X Burial 2 ☐ Cremation 3 ☐ Rai 4 ☐ Donation 5 ☐ Other (Specify)	movai from Stata	ematery, cremato Peter Cla			/7/98	St. Inig	oes, Maryland
Baltimo permit. Page Department of Important: If any injury or pace.	21. Signature of Funeral Service Licenses	6 // -	Mad	me and Addre	Canding	er Funer	al Home,	P.A.
	23a. Part1. Enter the disease, or complice shock or heart failure. List only one	ations that ceused the death cause on each line.	h. Do not enter th	O. Box ne mode of dyir	2/0, Leor	nardtown or respiratory ar	, Maryla rest,	Approximete Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e.	Conjes	tive	thes	nt to	21/00	<	4 45
je line	Tooding in county	Anterio	r as a consequen	ce of):	cardio	1)2 S C	- des	
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68760, ificate be expensed by the purial Edical E	ceuse. Enter Underlying Causa (Disease or injury that initiated events	B /						
E 0.0	resulting in death) Last	Due to (o	r as a consequent	ce or):				
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death death e attended for u	Part II. Other significant conditions contr	buting to death but not resi	ulting In the under	tying cause giv	en in Part I.	23b. Did t	obacco use cont	ribute to the causa of death?
that the death ce hed by the attending detached for use y Physician/						101	res 2□ No	3 Probably 4 Unknown
OT VItal RECORDS, P.O. BOY Physician: The law requires that the death ce this certificate has been signed by the attendi rel director, page 2 should be detached for us. TO Be Completed by Physician/							an autopsy med?	24b. Were autopsy findings aveilable prior to complation of causa of death?
The law ate hes pege 2						1 D Y	es 2 No	1 ☐ Yas 2 ☐ No
VITAL PI lician: The certificate rector, peg	25. Wes case referred to medical				26. Plece of Deet	h (Check only o	ne)	
Of VIta Physician: this certificated director,	examiner? 1 Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3	DOA Oth	ner: 4 Nursing Ho	me 5 💢 Resid	ence 6 Other	(Specify)
SION OT tanding Physicath. for: After this the funerel di catlon: To	27. Menner of Death 1 Neturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo M 1□			ow injury occurre	
or At ther of the or his	3 Sulcide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify		factory, office		28f. Location (S City or Tow		r or Rural Route Number,
DIVI To the Hospital or At within 24 hours after of to the Vocate Direct completely filled in by Medical Certifit	(Check only 2 Medical Examina	clan: To the best of my kno r: Op the basis of examinal						
thin 2 thin 2 the mple	20h Simetria and title of contilled	and manner stated.		29c, Licens	a combar		Od Date slaned	(Month, Day, Year)
To To Solo	29b. Signature and title of certifley	Jaroba	(44)-	bo	0506		05/0	4198
	30. Name and address of person who com	pleted cause of deeth (Item	n 23a) (Type, Prin	t)			1	, Md. 20659
	Leon W. Berube,	M.D. 281	170 010	Villa	ge Rd.	Mechai	nicsville	, Md. 20659
State	31. Date filed (Month, Day, Year)	32. Registrar's Signe	ture		,			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month May 07,1998 9:59p.m. RAMONA LYNN YUREK 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death ST. MARY"S HOSPITAL LEONARDTOWN ST. Mary's 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 1 M 2 X F Months Days Hours Yrs. 002-56-1266 38 Nov. 12, 1959 Mississippi Usual Residenca of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits lew lampshire Sullivan 1 Yes 2 No claremont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RFD # 3, Box 454 A 03743 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Merried 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Lab Technician Lab-Spear 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meidan Sumema) Paul Alfred Goewey, Jr. Margaret Anne Bullock 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Charles Edward Yurek RFD # 3, Box 454 A, Claremont, NH 03743 20a. Method of Disposition 20b. Pleca of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stete 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 5/14/98 Claremont, NH 03743 4 ☐ Donation 5 ☐ Other (Spacify) of Emeral Service Lice 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road 21. Signatu Edward N. Brinfield, Jr. M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final Sub arachnoid about 3 days disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequenca of) Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? completion of cause of death? 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Chack only ona) examiner? Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Ves 2 No 28a. Date of Injury (Month, Dey Yaer) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 DNaturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) Placa of Injury - At home, farm, street, factory, offica building, etc. (Spacify) 4 ☐ Homicide

The law requires that the death certificeta be executed NAME: RAMONA LYNN YUREK Division of Vital Records, P.O. Box 68760, Attending Physician:

and the buriel-tran physician usa as been signed by the attending should be datached for usa as certificate has spital or Attending Physhours after daath.
neral Director: After this y filled in by the funeral di this To the Hospital or within 24 hours aff To the Funeral DI completely filled in

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show

Directo

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Completed

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Pages 1 and 2 should be filed within 72 hours aftar death nent of Health and Mental Hygiene. If Itam 27 Is marked other than "natural", or itema 23

I Hygiene.

altimore, Maryland 21215-0020

7 is marked other than "natural", or items traumatic event, the Medical Examiner m

0 permit. Page Department of Important: If any injury or once.

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed Be 2 Certification: edical

29a. Certifier

(Check only one)

29b. Signeture end title of certifier

State Registrar

DHMH 16 Bay 6/95



29c. License number D 500

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the ceuse(s) end menner as stated.
2 Medicat Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Day, Year) May08, 1998

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

Mohammad A. Rahman Hollywood, MD. 20636

31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAY 13 1998

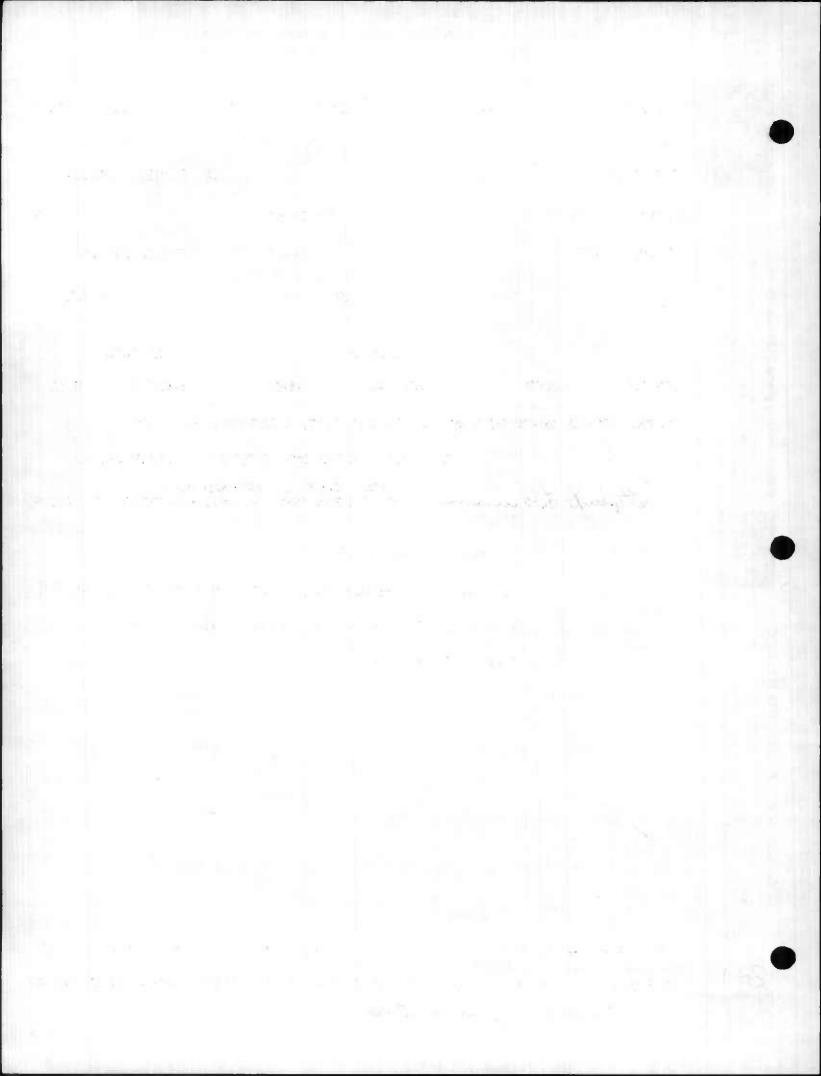


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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				ryland / Dep <i>Ce</i>	ertificate of		F	Reg. No.	17313			
П	Physician /Medical	Decedent's Name (First, Middle, LAWRENCE	(Last) HULL		ANDERSO		2. Date of Dea Month JUNE	Day 2	3. Time of Death 998 3:30 PM			
	Examiner Funeral Director	4a Facility Name (If not institution, 5 PUNTE LANE 5. Social Security Number 220 05 0936	S. Sex 7. Age	o (In yrs. last birthday 30 Yrs.		4b. City, Town, or L BALTIMOR If Under 24 Hrs. Hours Min.	E 8. Date of Birti (Month, Day	BA	ALTIMORE B. Birthpiace (State or Foreig Country) MARYLAND	gn		
Mandand	f show sed at	Usual Residence of Decedent 10a. State MARYLAND BALT	IMORE	10c. City, Town or L		LTIMORE			10d. Inside City Limite			
di di	r items 23a or 28a-f a stret_must be notified Funeral Director	10e. Street and Number 5 PUNTE LANE			10f. Zip Code	21221		10g. Citizen of Wh				
11215-0020	ai', or items in the control of the		12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates;		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 20X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: WHITE				
21215-0020	ygiene. nt. the Medical Completed	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	Education grade completed) College (1-4or 5-	+) (Give	edent's Usuai Occup e kind of work done DO NOT use retire	during most of work	king	16b. Kind of Busi				
pul a	Mental Hygie arked other a artic avent, th	17. Fathers Name (First, Middle, La	RUCE	ANDER	SON							
nore, Mar	of Health end fitem 27 is m r other traum	19a, Informant's Name/Reletionshi MARTHA REBECCA 2 20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Dother (Spa	ANDERSON/Dat	20b. Plece of Disponentery, cre	PUNTE LA			21221	Lity or Town, State			
Baltin	Department important: bany injury once.	21. Signature of Funeral Service Li		Ĉ	22. Name and Addre		HRMANN I	P.A.				
38760, Sales No. 1981		Cause (Disease or Injury that initiated events resulting in death) Last	b. CAN	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (SION advance of): ANEREP aquence of): RUCTIV quence of):	95 WIT	It ME	TASTAS				
Records, P.O. Box 6	n signed by the attending uid be detached for use ered by Physician/Me											
Records,	page 2 should to						1 🗆 Y	res 2000	available prior to completion of cause of death?			
Division of Vital	this certification all director	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	y 28b, Time	of 28c. Inju		ome 5 Aesid	dence 6 Other				
Divisi	within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Sulcide 6 Could no 4 Homlolde determin		ry - At home, farm, s . <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tox	Street and Number vn, Stete)	r or Rural Route Number,			
the Hosp	thin 24 hours the Funer impletely fill	29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es state (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner es state (Check only one)										
) (¥ 6 8	29b. Signature and title of certifier Saba Su 20 New and address of corrections	//	with litera PO-1 /Y	24	1496			(Month, Day, Year) 3 - 1998			
2	State Registrar	30. Neme and eddress of person with SABA SID SID SID SID SID SID SID SID SID SID	0101	eth (Item 23a) (Type 405 S.7 r's Signature Savidson—Ron	EMMERS	S RUN	ROAD	BALTU	MO 21221	•		

DHMH 16 Rev 6/95



Physician

/Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylend Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show eny injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Directo

Funeral

by

Completed

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	Pleas	se Type or P State of		nd / Depa	artment	of H	fealth a					ble.	7314	
				Cei	rtificate	of i	Death			Reg. N	lo.		1014	
Decedent's Nam ANI		Last)			BRATI	MAN			2. Dete of D Month JUNE		ay 199	Year	3. Time of Death 2:20 PM	
					DIALI		th City To	um or la	cation of Dee		-	of Death		
2624		give street and numb	rer)								c. County	or Death		
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213-34-1 Usual Residence of	1552	1□ M 2X F		88 Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Yea	Year) Country) 1909 MD			
10a. State	10b. County		10c. Ci	ty, Town or Lo	cation								10d. Inside City Limits	
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10e. Street and Nu	mber				10f. Zip (Code				10g. C	itizen of	What Cou	untry?	
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	position Cremetion 5 Other (Spe		ete	Placa of Dispo cametery, creat ATOMICA	matory or oth	e of her pla RD	ce)	6,	STERSTY /4/98 l Levii	20c. BA	LTIM	ORE,	Town, State	
23a. Part1. Enter shock, or her	ert failure. List o	complications that can any one ceuse on each	th line.	th. Do not en	ter the mode	of dyir	ng, such as	stow) cardiac	n Road or respiratory	Bal			MD 21208 Approximate Interval Between Onset and Death	
resulting in death)		θ		or as a conse								1		
Sequentially list co if eny, leading to it cause. Enter Und	nmediete =	b	Due to (or as a conse	quenca of):							1		
Ceuse (Disease of that initiated event	r Injurý s	c	Due to (or es e consec	nuence of):						_	+		
resulting in death)	Lest	d												
Part II. Other signi	ficant condition	s contributing to dea	th but not res	sulting In the u	inderlying ca	iuse giv	ven in Part I				2 No		to the cause of death?	
										tormed		8	Were eutopsy findings available prior to completion of cause of death?	
									10	Yes	2X No	1	I ☐ Yes 2 ☐ No	
25. Wes case refe examiner?	rred to medical					1		of Deal	h (Check only	one)				
1 X Yes 2	No	Hospitel: 1 🗆 in	patient 2	ER/Outpatle	nt 3 DO	A Oth	ner: 4 🗆 Nu	irsing Ho	me 5 ⊠ Re	sidence	6 🗆 Ot	her (Spec	oify)	
27. Menner of Dee 1 XNatural 2 ☐ Accident	5 Pending Investiga	f Injury h, Dey Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No												
3 Suicide	6 Could no	01.06	A barbaran A habi	ome farm st		-46-0			20f Location	(Stroot	and Alum	har or Bu	ral Route Number.	

Physician /Medical **Examiner**

Examiner the attending physician end thed for use es the buriel-transit Physician/Medical deteched for signed by by 8 Completed peed

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, page 2 should After this certificate hes Attending Physician: Be ertification: To funeral

3 Suicide determined 4 Homicide

building, etc. (Specify)

City or Town, State)

29b. Signeture end title of certifier

29a. Certifier

(Check only one)

29c. License number O.C.M.E.

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and pleca, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) JUNE 02, 1998

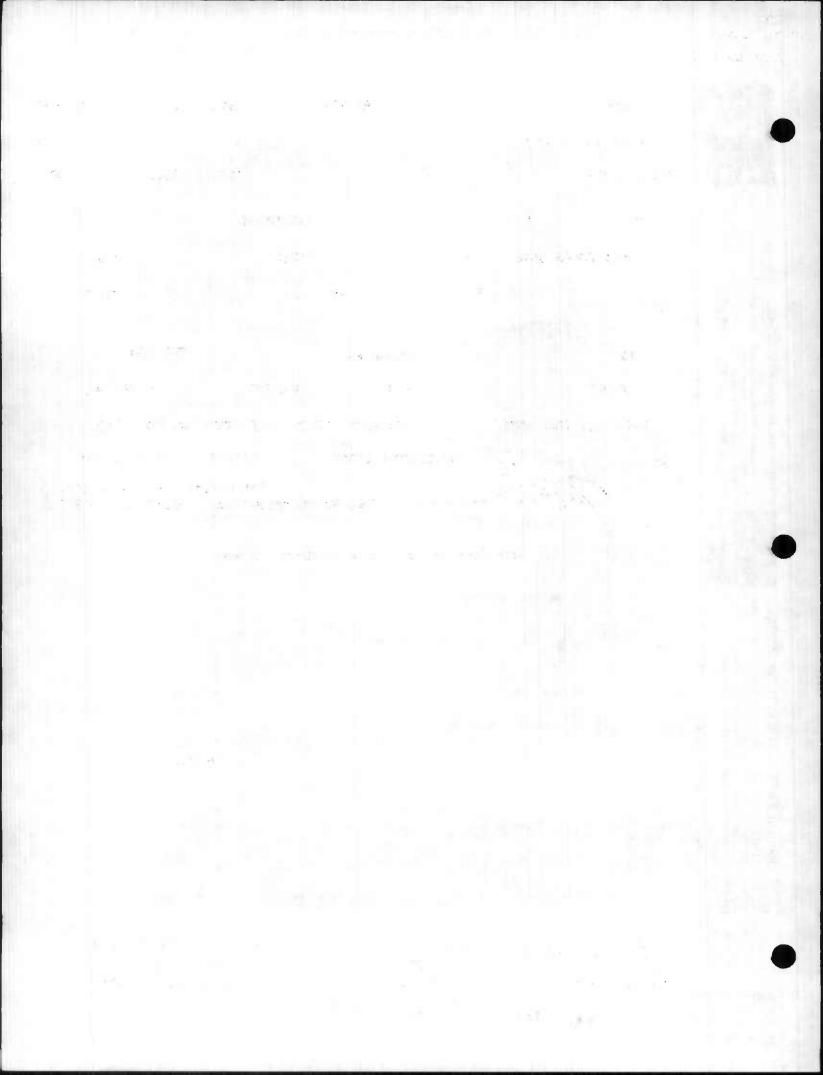
MY 30. Name and address of person who completed cause of death (Ifem 23e) (Typa, Print)

Stephen Radentz, M.D.

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signeture 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:05 pm Becoate Garrett ovence /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner enter Balt:more Hospital larbor Hours Min. 8. Dete of Birth (Month, Dey, Year) 5-29-1919 If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1□M 200(F 217-09-9073 84 Vrs Va **Director** Usual Residence of Decedent with the Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Ma Yes 2 No saltimore Director NA 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 3720 21207 . S.A armon Hornue Funeral permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health end Mental Hygiene. Important: If items 72 is marked other than "natural; or items 234 any lightry or other traumatic event, the Medical Examine main 14. Race - American Indian, Bieck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1□ Yes 2□No Baltimore, Maryland 21215-0020 Black Specify: þ 3 DWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Manor Care Elementary/Secondary (0-12) College (1-4or 5+) Nursing assissfant WA (out grade 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Garrett Garrett 12210 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Grenue Baltimore, Md Z1207 - Daughter armon 20b. Pleca of Disposition (Neme of cemetary, crematory or other plece, 20c. Location - City or Town, State 20e. Method of Disposition Important: If its any injury or o once. 1 Buriai 2 □ Cremetion 3 □ Removel from State 6-6-98 4 Donetion 5 ☐ Other (Specify) em et ery 22. Name and Address of Feculty Less 21. Signature of Fyneral Service License 21215 Sa HU, HO Wabasi 0 for the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, heart tailure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** farction of Brain Immediate Cause (Final disease or condition resulting in death) /Medical 48 hours Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68769. Due to (or es e consequence of): the th 98 esn esn 23b. Did tobacco uss contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown partension à 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? certificate has b irector, page 2 s 2 NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mpatient 3□ DOA 2 ER/Outpatient After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? Certification: or Attending 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, ferm, street, tectory, office building, etc. (Specify) 3 4 Homicide 24 hours after
 Funeral Dire
 idetely filled in b Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

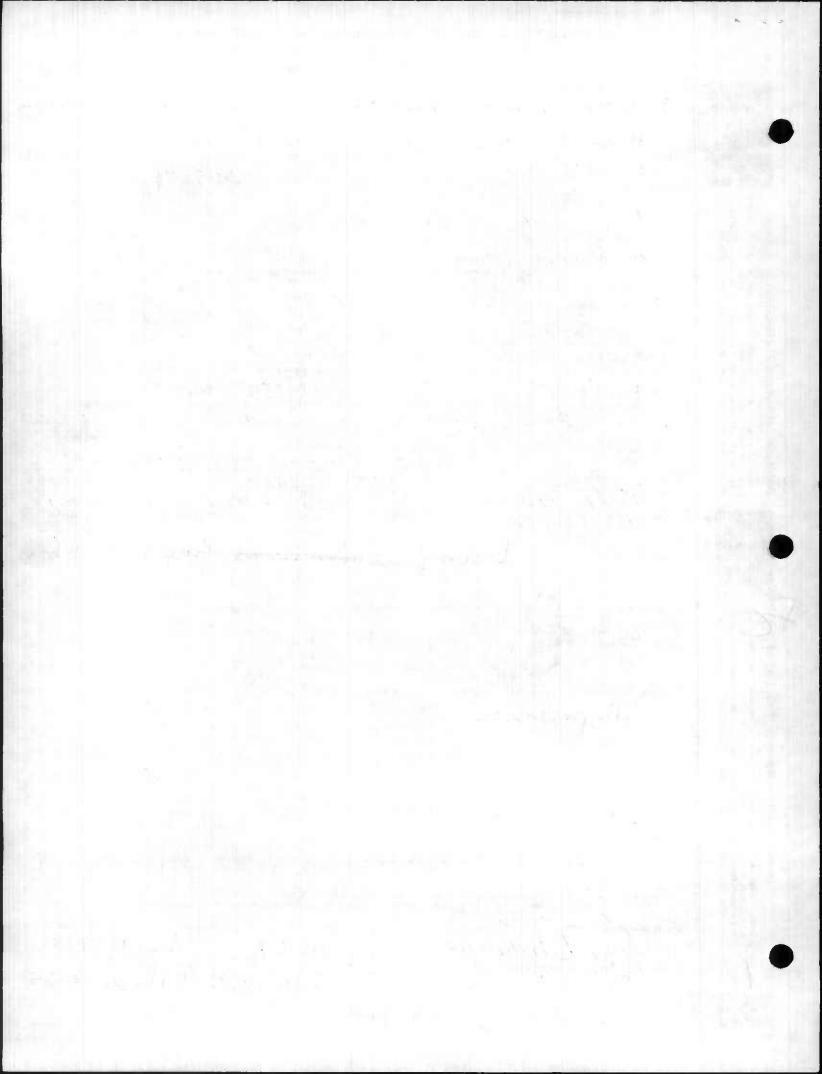
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menoer stated. 29e. Certifier edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29h. Signat 29c. License number Illiams I Le address of person who completed cause of deeth (Item 23a) (Type, Print).

State Registrar 31. Dete tiled (Month, Day, Year)

JUN Q 4 1998

32. Registrer's Signeture

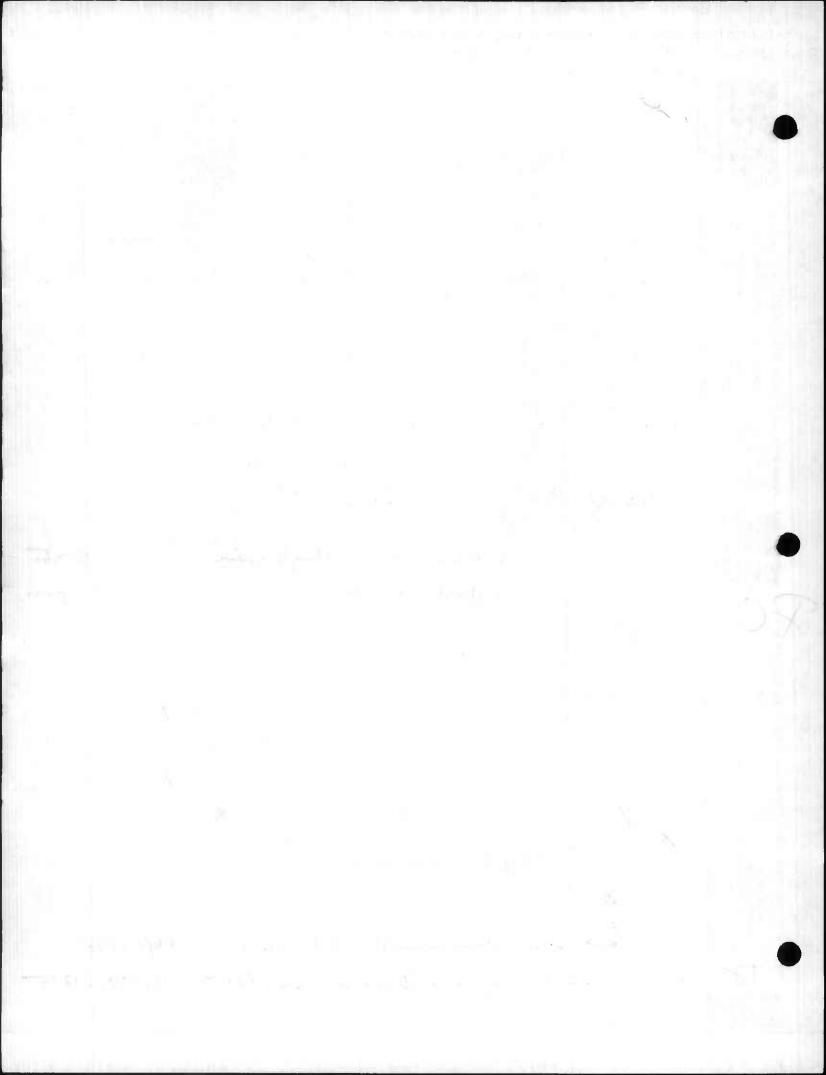
Fulia Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gertificate of Death

						Certifica	ate of	Death		Reg.	No.		010			
			1. Decedent's Name (First, Middla, L.	ast)					2. Data o	Death		Marie I	3. Tima of Daath			
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Mai yiaila 2 12 13-0020	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show summit event, the Medical Examiner must be notified at	by	1 ☐XNever Marriad 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant E- Armed Forcas? 1 A Yas 2 □ No If Yas, Giva Yaar or Dates:	WWII		2 No	an, Maxican, F Specity:	n? (Specify Yas o Puarto Rican, atc.			k, Whita, at	c.			
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נו	deal deal		20a. Mathod of Disposition	es (Miece)		of Disposition (A		0.101	Data	-	1 ocation -	City or Tow	n State			
ballilliore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti once.		1 Bunal 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) 1 In Wood Cemetery 6/5/98 Oxford, NC										ri, Stata			
Š	Depa Impo		21. Signatura of Funaral Service Charges 22. Name and Addrass of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena. Maryland 21122													
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that causad to	ha death. Do	o not antar tha m	ode of dyir	g, such as ca	rdiec or raspirato	y arrest,			Approximata ntarval Between			
١	Physician	In Co., or heart failure. List only one cause on each lina.														
	/Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in deeth) a. Caudiac authylthuca 10 mts													
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2	ather for s	Physician/										I.				
j.	8 66	Jysi	Part II. Other aignificant conditions	contributing to death but	not rasulting	in tha undarlying	j causa giv	an In Part I.			10		he cause of death?			
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	The law ate has b page 2 s	E							1	☐ Yas	2 No	10	Yas 2□ No			
Alid	clan: artifica actor, j	Bec	25. Wes casa referred to medical					26. Place of	Death (Check or	nly ona)	/ .					
	E 49	2	axaminar? 1 ☐ Yas 2 X No	Hospitel: 1 Inpatian	2 ER/0	Outpatiant 3 1	DOA Oth	ar: 4□ Nursi	ng Homa 5 X	asidanca	6 □Oth	ar (Specify)				
	Attending Ph ir death. ector: After th by the funeral		27. Mannar of Death 1 Natural 2 Accident 1 Accident		Year) 28b	. Tima of Injury M	28c. injur Wor 1 🗆	yat k? Yas 2 □ No	28d. Dascr	be how in	njury occurr	red				
		Certification:	3 Suicida 4 Homicide 3 Suicida 4 Homicide 3 Suicida 4 Homicide 4 Homicide 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)										Routa Number,			
	To the Hospital or within 24 hours aft To the Funeral Discompletely filled in	edicai	29a. Cartifier (Check only one) Certifying Property 2 Medical Example (Check only one)	nyaician: To the best of miner: On the basis of a and mannar state	xaminetion e	ge, daeth occurre end/or invastigatio	d et tha tin on, in my o	na, data end p pinion, daath	plece, and due to occurred at the tir	the causa na, dete a	a(s) and ma and piece, e	nnar as statend due to the	ted. ha csusa(s)			
	To the Vithin To the compli	×	29b. Signetura and the of certifier 29c. Licansa number 29d. Data signed (
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	17		30. Name end eddress of parson who L. SEENIVAS	complated causa of dea	606) (Type, Print) Hamm	uno	Ls LN	BALT	Ime	DRE,	MD.	21225			
	Sta Registi		31. Data filed (Month, Day, Yaar)	998 32. Ragistre	s Signatura	doon-Rand	100		,			- 1				

DHMH 16 Rav 6/95



Physician

/Medical

Examiner

1. Decedent's Nama (First, Middla, Last)

Helen

4a Facility Nama (If not institution, giva street and number)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

HELEN BUTLER

State of Maryland / Department of Health and Mental Hygiene Items: 23 part I,27 per MEO G-760 6/10/98 reb Certificate of Death

Butler

Ρ.

	Reg. No.	J	0	
2. Data of	Death			

01, 1998

4c. County of Death

ANNE ARUNDEL

USA

14. Race - Amarican Indian.

Retail Sales

Maryland

Approximate Interval Batween Onset and Daath

Stone

Black, Whita, atc.

Month

JUNE

4b. City, Town, or Location of Death

3. Time of Death

4:46P.M.

Birthplaca (State or Foraign Country)

White

10d. Inside City Limits

1 Yas 2 No

1948 Massachusetts

206 SPRING MAIDEN COURT GLEN BURNIE If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2XF Months Days Yrs. 012-40-4068 49 Director Usual Rasidance of Decedant death with the Maryland 10a Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or flams 23a or 28a-f ahow traumetic avent, the Medical Examiner must be notified at Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 206 Spring Maiden Court 21060 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after.
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or flee
any Injury or other traumatic avent 1 Nevar Marriad 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 XNo Spacify: by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Customer Service 18. Mothar's Name (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Louis Fox Rita 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. tnformant's Name/Ralationship (Type, Print) 1211 Holmewood Dr. Pasadena, Md. 21122 James B. Butler (Son) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 Burial 2 Cramation 3 Ramoval from Stata Metro Crematory Inc. 6/2/98 Baltimore, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Stallings Funeral Home PA 21. Signatura of Funeral Sarvice Li 3111 Mountain Rd. Pasadena. ns that caused tha death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, used neach line. 23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical FATTY LIVER Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequantially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): certificate be exec Box 68760. Physician/Medicai Dua to (or as a consequanca of) 80 attending nse n P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by 1 Yes 2 No Division of Vital Records, þ 8 24a. Was an autopsy performed? Completed peeu certificate has 1 Yas 25. Was cesa rafarred to medicel axaminar? Be 26. Place of Death (Check only ona) Hospital: To 1 Nas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28d. Dascribe how Injury occurred 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Investigation XX Natural 1 ☐ Yas 2 ☐ No n 24 hours after deeth. Te Funeral Director: A deeth. 2 Accidant 6 Could not be datarmined 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 3 Suicida 4 Homicida 29a. Certifier 1 Cartifying Physician: To tha best of my knowledga, daath occurred at the tima, data and place, and dua to tha causa(s) and manner as stated edical (Check only one) 2 XMedical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the vithin 2 5 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licansa number

30. Name and address of person who complated ceusa of death (Itam 23a) (Type, Print)

Radentz, MD

32. Ragistrar's Standture

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of death? 2 - No 1 Yas 2 No 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

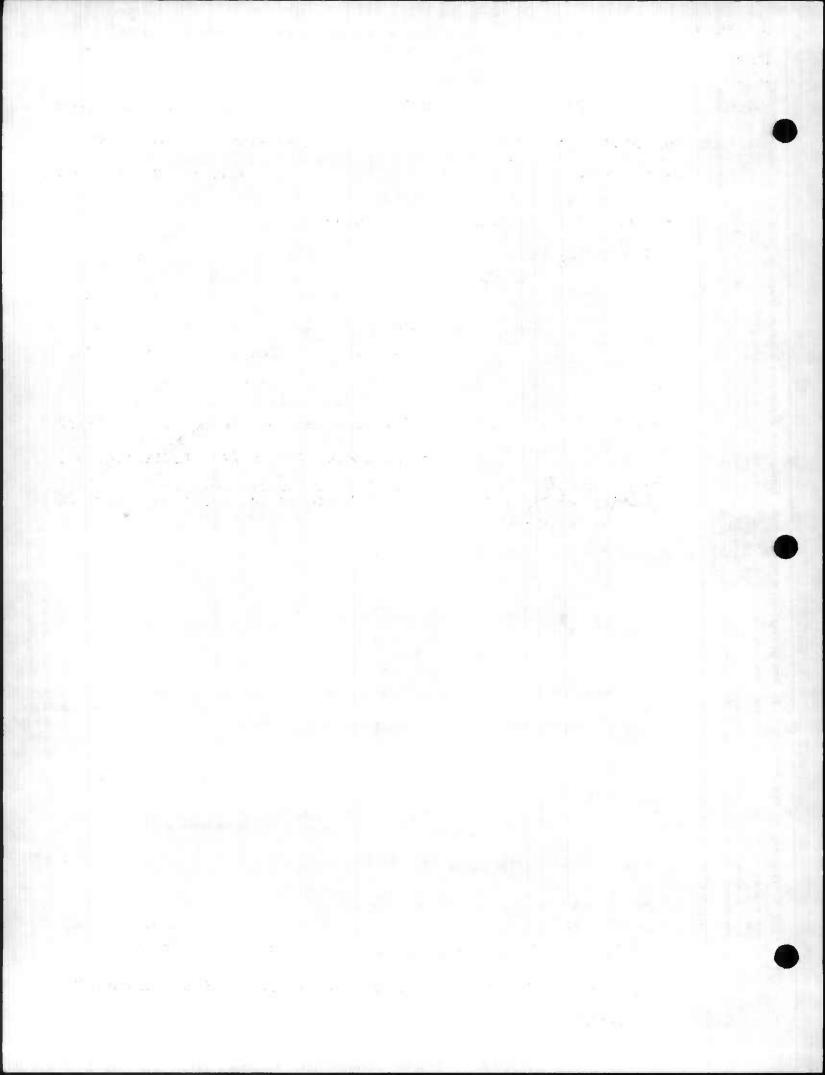
JUNE 2, 1998

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

State Registrar Stephyn 31. Data filed (Month, Day, Year)

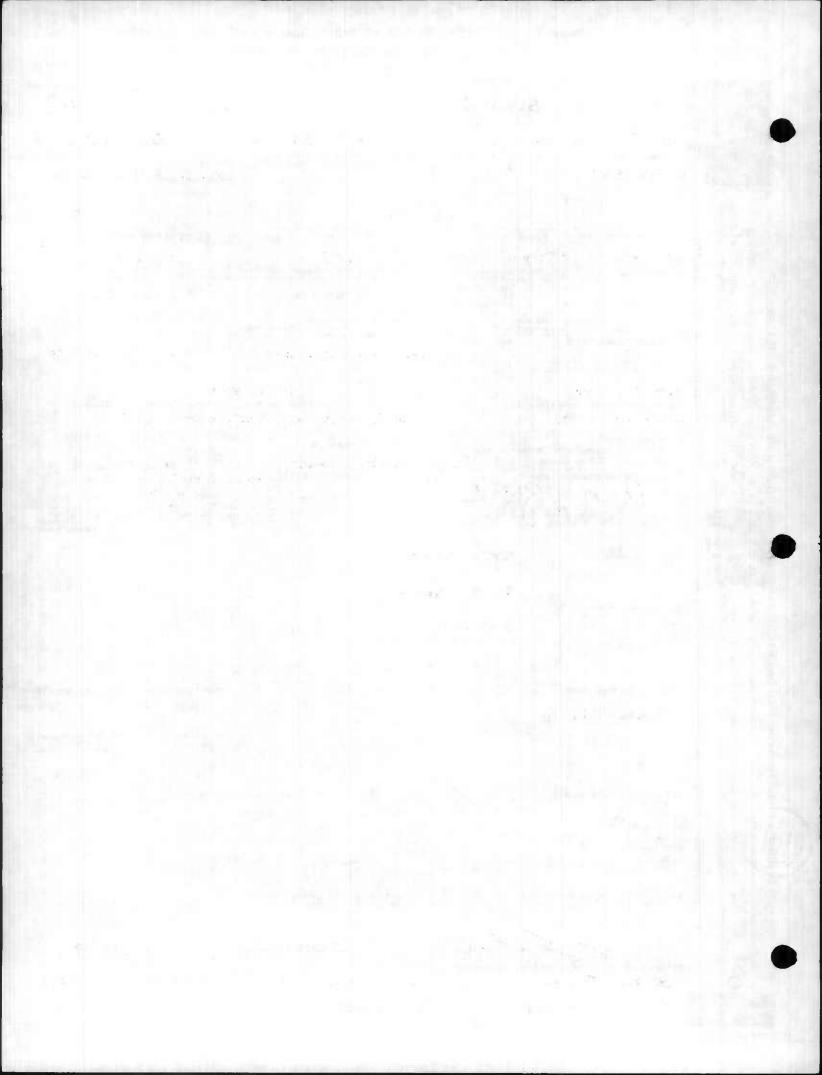
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State of Maryland / Department of Health and Mental Hygiene 9 8 173 | 8

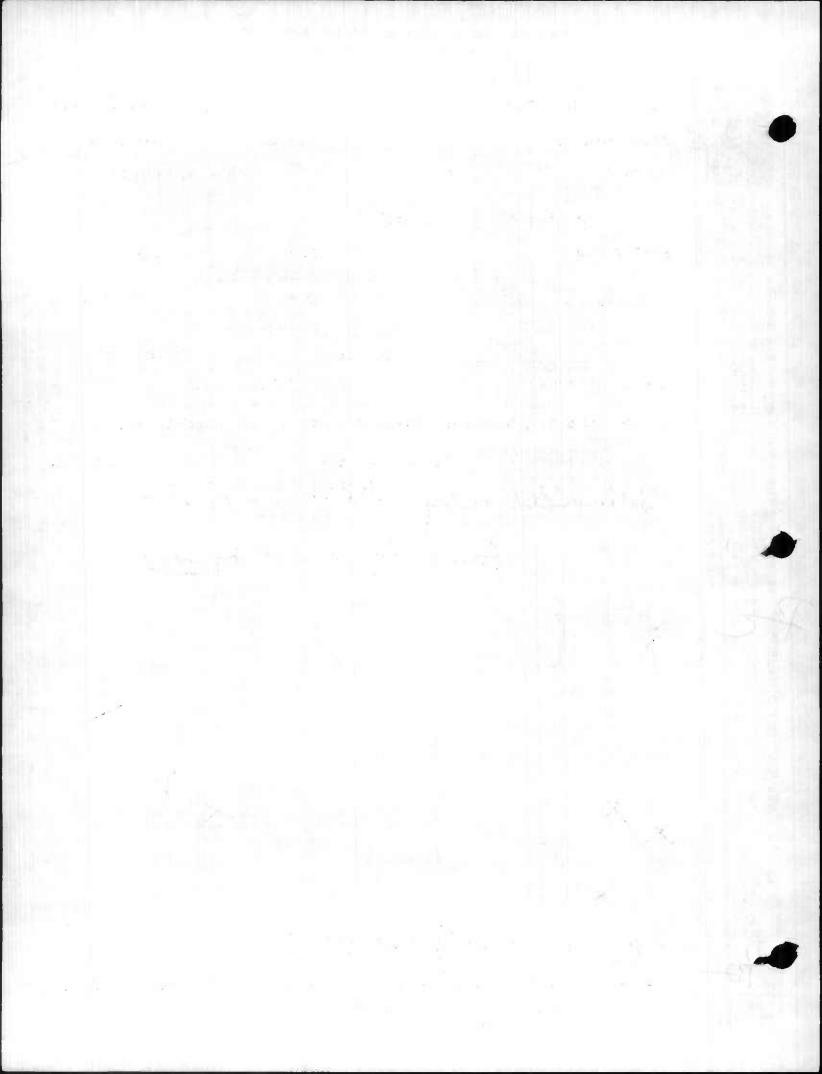
ian							te of				Reg. No.			
:ian	1. Decedent's Nam-	e (First, Middle, La	-							2. Date of De	eath Day	Year	3. Time	of Death
ical		DLIVE	BUGAR	17						06	O (98	05	2
ner	4a Facility Name (/	If not institution, giv	re street and numb	ber)			4	4b. City, To	wn, or Lo	cation of Deat	h 4c. Count	y of Death		
	UNIVERSI	TY OF M	URYLINE	MED!	CHC S	SYSTE	N	BALT	nne	26	BAL	DMD	2E C	TY
	5. Social Security N	lumber 6. S	Sex , 7.	Age (In yrs.			er 1 Year	If Under		8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)				
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	10a. State	10b. County			y, Town or L							1	0d. Inside	City Limits
to	MD	n/a		Bal	timore	e							1 X) Y	s 2 No
Director	10e. Street and Nu	mber				10f. Zi	ip Code				10g. Citizen of	What Cour	try?	
0	130 South	Carey S	treet			2	1223				United	Stat	96	
Jer	11. Marital Status	. darey b	12 Was Deced	ent Ever in U	S. 13.			lispanic Ori	gin? (Spe	city Yes or No Rican, etc.)		ce - Americ	en indian,	
by Funeral	1 Never Marri	ied 2 Married	Armed Forc	△ No					i, Puerto i	Hican, etc.)		ick, White,		
þ	3 D Widowed	4 Divorced	If Yes, Give Year or Date	es:		1 Yes	2 No	Specify:			Speci	y: Whi	re	
Completed		15. Decedent's Ed	ducation		16a. Dece	edent's Usi	ual Occup	ation			16b. Kind of E	Business/Inc	dustry	
piet		cify only highest gra		(n. 5.)	(Give	e kind of w DO NOT	ork done i use retired	during mos	t of workir	king				
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	17. Fether's Name	(First, Middle, Last,)	- AT						(First, Middle	, Malden Suma		0	
o Be	Robert Le	Rland						A150	rta (Cormier	. 1-010			
2	19a. Informant's Na		Type Print)		19h Meii	iina Addres	ss (Street				per, Clty or Town	State Zin	Code)	
	Heidi Ric										MD 212			
-	20a, Method of Disp			20b. F	Pleca of Disp	osition (Ne	eme of			Dete	20c. Location		wn. State	
	1 Burial 2	XCremation 3		ate	ametery, cre	ematory or	other plac	ca)	1			,		
		5 Other (Specif	•	For	t Line	coln	Crema	atory	(6/4/98	Brent	wood,	MD	
	21. Signature of Fu	ineral Servica Licer	nsee .	,	2	22. Name a	and Addre	ss of Facilit	Loud	lon Par	k Funer	al Ho	me	
	21. Signature of Funeral Servica Licensee . 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, MD 21229													
	23a. Part1. Enter the shock, or hea	he disease, or com	plications that cau	sed the deat	h. Do not er	nter the mo	de of dylr	ng, such as	cardiac o	r respiratory	arrest,		Approxin	ate
	GHOOK, OF HOL	ire landio. Elaconiy	One and on our	J1 1110.									Onset an	
	Immediate Cause	(Final	3,500	0 911	V									
	Immediate Cause (Final disease or condition a. SSPTC SHock resulting in death)													
ē	Due to (or as a consequence of):													
直			0):							
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sai Exa	Sequentially list co if any, leading to In cause. Enter Unde Ceuse (Disease or that initiated events	enditions, nmediate orlying injury	0.	Due to (c	Bouce or as a conse	equenca of):							
edical Exa	Sequentially list co if any, leading to in cause. Enter Unde Ceuse (Disease or that initiated events resulting in death)	enditions, nmediate orlying injury s Last	0.	Due to (c	Shows	equenca of):							
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Medical	Sequentially list co if any, leading to in cause. Enter Unde Ceuse (Disease or that initiated events resulting in death) I	Last	d. EVI	Due to (co	Bosuca or as a conse or TS.	equence of):	ven in Part i			tobacco use c			
Physician/Medical	Pert ii. Other signif	licant conditions of	cCAL	Due to (co	Bosuca or as a conse or TS.	equence of):	ven in Part I			l tobacco use c			e of death
by Physician/Medical	Pert ii. Other signif	Last	cCAL	Due to (co	Bosuca or as a conse or TS.	equence of):	ven in Part i		1	Yee 2□ No	3 ☐ Pro	bably 4	Unknow
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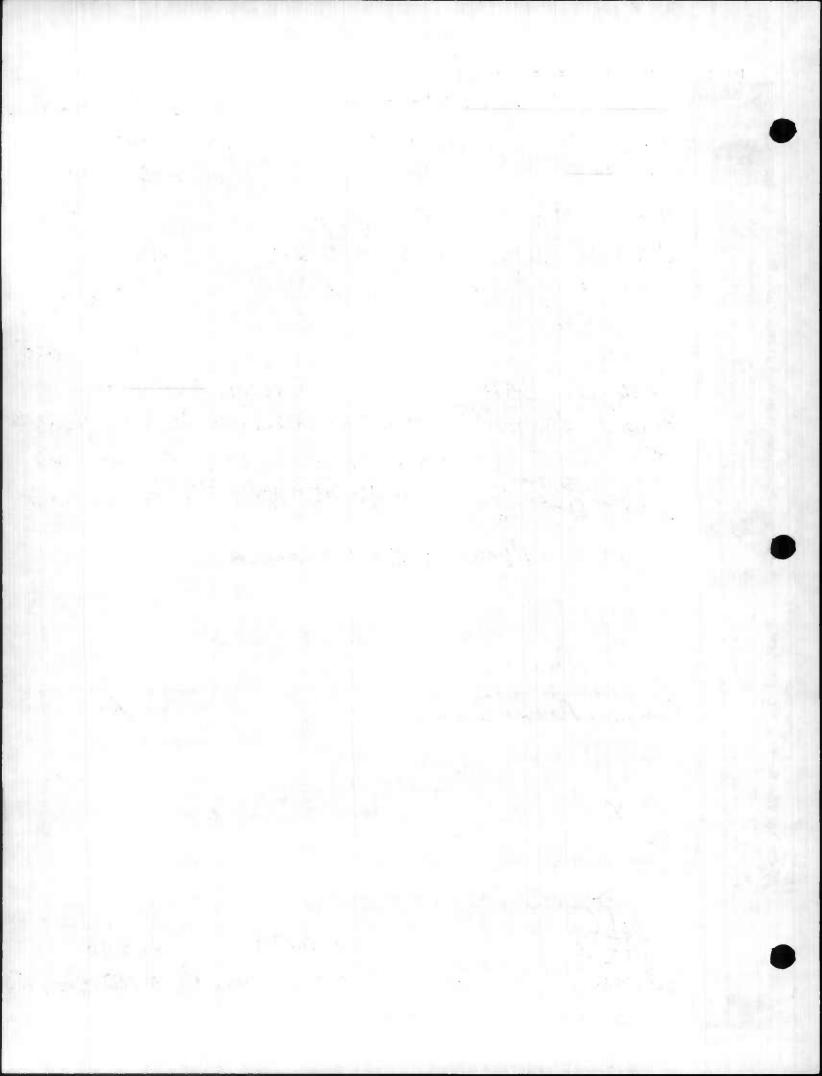
State of Maryland / Department of Health and Mental Hygiene 8 | 73 | 9

			Certifica	ate of Death	R	eg. No.	17012		
	1. Decedent's Neme (First, Middle, Last)			2. Date of Deel Month	th Dey Year	3. Time of Death		
Physician /Medical	Robert C.	Bruchey			June	1, 1998			
Examiner	4e Fecility Neme (If not institution, give	street and number)		4b. City, Town, or	Location of Deeth	4c. County of De	eth		
	3120 Yorkway			Dundal		Baltim	ore		
Funeral Director	220-36-7120	x 7. Age (In yrs XM 2□ F 57	Yrs. If Und Month	der 1 Year If Under 24 Hrs Is Deys Hours Min	. (Month, Day,	, Year) 9. B	irthplece (Stete or Foreign Country) D		
death with the Maryland ms 23s or 28s-f show r next be notified at neral Director	Usual Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits		
or Po	MD Baltim		Dundalk				1 ☐ Yes 2 ☒ No		
ect ser	10e. Street end Number	lore I		Zip Code	4	Og. Citizen of Whet C	Countral 2		
ritams 23s or 28s-fs directional be notified Funeral Director	3120 Yorkway			21222		USA			
or the countries by Fu	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates:		cedent of Hispenic Origin? (specify Cuben, Mexican, Puel 2X No Specify:	Specify Yes or No- to Rican, etc.)	Bieck, Wh	nerican Indien, nite, etc. White		
ygiene. er than "naturi ft, the Wed cell Completed	15. Decedent's Edu (Specify only highest great Elementery/Secondary (0-12)	le completed) College (1-4or 5+)		suai Occupation work done during most of wo use retired)	orking	16b. Kind of Busines			
ther to the Co	17 Fethode Name (First Middle Leet)	2	Electri		me (First, Middle, I	Beth - S	steel		
and Mental H is marked off sumatic ever	17. Fether's Name (First, Middle, Last) Charles Bruche	V			n Bruche				
Merrico TO									
Is I	19e. Informent's Name/Reletionship (T)			ess (Street end Number or F			2103		
Health em 27 ther tr	Sharon Cannon 20e. Method of Disposition	/daughter	10154 G	rapevine Ro		dela Spri 20c. Location - City of			
nent of H	1 Burial 2 Cremetion 3 F 4 Donation 5 Other (Specify)	Removel from State	cemetery, cremetory of	r other place)	June 5	Catonsvi			
Department of Important: If any injury or once.	21. Signeture of Funeral Service Licens	+ Com 11	22 Name Con 711	and Address of Facility nelly Funer O Sollers 1	ral Home				
nysician Medical kaminer	23a. Perfi. Enter the disease, or comp shock, or heart feilure. List only of Immediate Cause (Final disease or condition resulting in death)	. Aud	e Me	ode of dying, such es cardia	afu	etin	Approximate interval Between Conset end Deeth		
an ind interburati Examine	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (Due to (or es e consequenca of):						
and physical se as the pur Medical	resulting in deeth) Lest	Due to (or es e consequence o	f):					
intendiction for use									
detached detached Physic	Pert II. Other significant conditions co.	ntributing to death but not re	sufting In the underlyIn	g cause given In Pert I.			rea to the cause of death?		
should by					24e. Wes a perfor		b. Were autopsy findings aveilable prior to completion of cause of death?		
page 2					1 🗆 Y	es No	1 ☐ Yes 2 ☐ No		
certificate rector, psi	25. Wes case referred to medical			26. Place of De	eth (Check only or	ne)			
direc O B	examiner?	Hospitei: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other:	1	enca 6 □Other (St	pecify)		
After this funeral di	27. Marrier of Beath	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. injury et Work?	-	ow injury occurred			
within 24 hours after death. To the Funeral Director, After incompletely filled in by the funer. Medical Certification:	2 Accided Investigation 3 Suicide 6 Could not be 4 Homicide	28e. Placa of Injury - At I building, etc. (Special	nome, farm, street, fact		28f. Location (S City or Town	itreet end Number or n, Stete)	Rural Route Number,		
n 24 hours ne Funera pletely fille edical C	29e. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my known: On the basis of examinand menner stated.	owledge, deeth occurration and/or Investigati	ed et the time, dete end plac on, in my opinion, deeth occ	a, end due to the courred et the time, d	ause(s) end manner dete end plece, and d	as stated. ue to the cause(s)		
within 24 To the Fu complete	29b. Signeture and title of certifier	wall	f up	29c. License number		29d. Date signed (Mo	onth, Dey, Year)		
12	30. Name end address of person who calle	11		th Point Ro	Rel+	more Mr	21224		
State	31. Dete filed (Month, Day, Year)	32. Registratis Sign	etura Randa	Ca.	ı Dartı	more, MI	21224		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#1per Phy, Item#5, 18 per FH G760 6/12/98 EW Reg. No. 2. Data of Daeth 3. Time of Death 1. Decedent's Nama (First, Middla, **Physician** Evelyn Ruth Branch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva streat and number) Examiner 5. Social Sacurity Number 6855 6. Sex Birthplaca (State or Foreign Country) **Funeral** Days Hours 1 M WF 214-30-6555 Usual Rasidance of Decedent **Director** 10a. State 10b. Count 10d. Inside City Limits the Maryler permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic svent, the Medical Examinar must be notified at MD 1 Yas 2 No Director 10e. Street and Number 10g. Citizan of What Country? QU Funerai 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indien, 11. Maritef Status rmed Forces? Black, White, atc. 1 Navar Merriad 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Lac þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/industry Collega (1-4or 5+) Elemantary/Secondary (0-12) Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Thrower Spouce 19b. Mailing Addrass (Speet and Number or Runs 2007 Balto. 4021216 20b. Placa of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 6-6-1998 4 ☐ Donation 5 ☐ Othar (Specify) CEMETERY 21. Signatura of Funaral Sarvica Licansae 22. Nama and Addrass of Facility Balto. 40 2/2/1 101 2 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting In death) Examiner Dua to (or as a consequanca ot): Examine physician and the burial-transit Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) the death certificate be execu P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): as 980 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Probably 4 Unknown 1 Yes 2 No by Records, 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s has Vital 25. Was casa refarred to medical axaminer? 26. Placa of Daath (Check only ona) Be axaminer? Hospital: Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpetient 3 DOA Residanca 6 □Othar (Specify) 9 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of Certification: 28c. Injury at Work? 5 Panding Invastigation 2 Accident 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 ☐ Suicida 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicide 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and mannar as atated. 29a, Certifie Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Data aigned (Morth, Day, Year) 29b. Sign 29c. Licansa number and addrass of person who complated causa of daath (Item 23a) (Type, Print) tiled (Month, Day, Year) 32. Registrar's Signatura 31. Data State JUN Q 4 1998

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Deeth May 31, **Physician** Ruth S. Burgess 7:30pm /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** St. Agnes Nursing & Rebab Center Ellicott City Howard County 7. Age (In yrs. last birthday)
And Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year)
August 10,1907
Maryland 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1□ M 2□ E 213-01-4954 Director Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f shov the Medical Examiner must be notified at Maryland Howard County Ellicott City 1 Yes X2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21043 3000 N. Ridge Road USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Black, White, etc. 11 Maritai Status e filed within 72 hours after all Hygiene.
other than "natural", or item 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Dates: 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes ※ No Spacify: speawhite þ 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 homewalter own home 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) 12 should be fill and Mentel H Be James H. France Ella Lilly 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Peges 1 end 2 st Department of Health and Important: If Item 27 is n any Injury or other traun Ms. Madeline Flack/neice 702 Covington Court, Eldersburg, MD 21784 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete XEBurial 2 Cremetion 3 Removal from State Good Shapherd Cemetery **3JUN98** Ellicott City, MD 4 Dopation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Slack Funeral Home, P.A. 23a P. III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, Approximate a process of the control of the Intervel Batween Onset end Deeth **Physician** /Medical Immedieta Cause (Finel ACUTE RESPIRATIONY FAILURE disease or condition resulting in deeth) Examine Examiner ASPIRATUM PERPRENT physician end the buriel-transit Sequentietly tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of) Box 68760 Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BACTORIAL INFUNION 1A þ 24a. Was an eutopsy periormed? 24b. Were eutopsy findings eveilable prior to completion of cause of daath? Completed DEMENTIA 2 No 1 ☐ Yes 20 No certificate Division of Vital unity death.

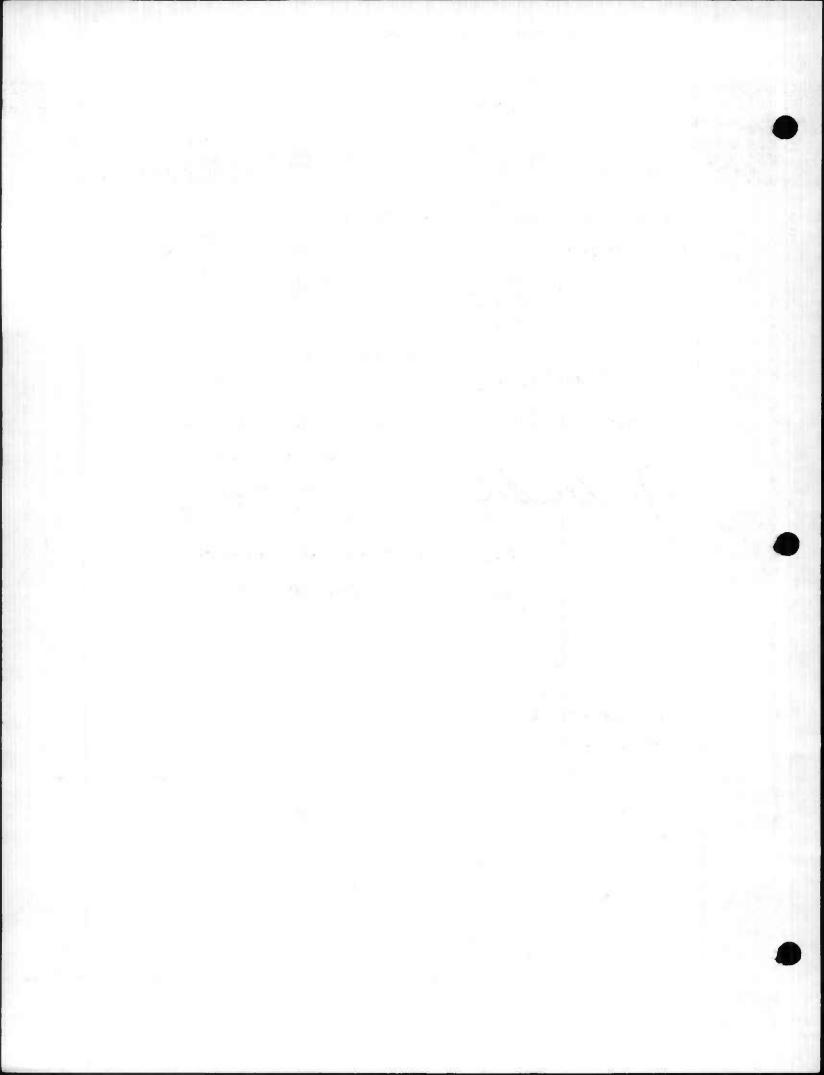
Director: After this certifica 25. Was case rafarred to medical exeminer? 8 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury et Work? 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 281. Location (Streat end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Phyelclen: To the best of my knowledga, death occurred et the time, date end plece, end due to the ceusa(s) end mannar as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and titla of certifier D36974 JUNE 1, 1998 30. Nama and addrass of varson who completed cause of death (Itam 23a) (Type, Print)
DAV 10 NYANISM 10724 UTTLE PATUXENT PARKWAY, COLUMBIA MD 21044 32 Registrar's Signature 31. Data filed (Month, Dey, Year)

DHMH 16 Rev 6/95

State

Registrar

JUN 0 4 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Collins JYN'E 1998 Rohert 2:30a 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE CITY Baltimore City THE JOHNS HOPKINS HOSPITAL If Under 24 Hrs. Hours Min. If Undar 1 Year Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 6. Data of Birth (Month, Day, Year) 1₩ 2□ F Months Days 218-70-1134 42 March 2, 1956 Olney, Maryland Usual Residanca of Dacedan 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Naryland 10e. Street a 3940 No 1 Yas 200 No Howard Ellicott City 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 3940 New Out Road 21043 TISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, 11 Marital Status Black, White, atc. 1 ☐ Yas 2\No If Yes, Give XXX Navar Marriad 2 Married 1 ☐ Yes 2 ☒️No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) College (1-4or 5+) Elementary/Secondary (0-12) 10 general contracting building 18. Mothar's Nama (First, Middle, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Louis Ringley Isabelle Collins 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3940 New Cut Road, Ellicott City, Maryland 21043 Ms. Mary Collins 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State TRuriai 2 Cremation 3 Removal from Stata Crestlawn Memorial Gdn. 5JUN98 Marriottsville, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Euneral Service Licensee 22. Nama and Addrass of Facility Slack Funeral Home, P.A. Ellicott City, Maryland 21043 mode of dying, such as cerdiac or respiratory arrast, M00535 and. Enter the disease, or complications that ceusad tha death. Do not antar the mode of dying, such as cerebook, or heart failure. List only one cause on each line. Approximate Intarvai Between Onsat and Death mediata Causa (Final to mediata Causa (disaasa or condition resulting in death) twelve hours elue hours Acidemia Sequantially list conditions, if any, leading to immediata ceusa. Entar Undarlying Causa (Diseasa or injury that initiated events Due to (or as a consequence of) causa (Diseasa or inju-that initiated events rasulting in death) Last Dua to (or as a consequence of): Cirrhosis 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 26. Place of Daath (Check only ona)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

þ

Completed

Funeral

Director

with the Maryland

Pages 1 and 2 should be filed within 72 hours efter death with the Marylan neat of Health and Mentel Hyglene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-f show any to their terms 20s or 28s-f show any or other traumatic svent, the Medical Examinar must be notified as

altimore, Maryland 21215-0020

physicien and s the buriel-transit certificate be axecuted P.O. Box 68760, signed by i Records, peeu certificate Division of Vital Attending Physician: this Affer death. Director:

or A

To the Hospital o

Physician/Medical

2

Completed

Be

2

Certification:

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. renal insufficiency 25. Was cesa rafarrad to medicei Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledga, dasth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. Licanse number

RES-000

29d. Data signed (Month, Day, Year)

June 2, 1998

State Registrar 31. Data filed (Month, Day, Year) JUN 0 4 1998

29b. Signature and titla of certifiar

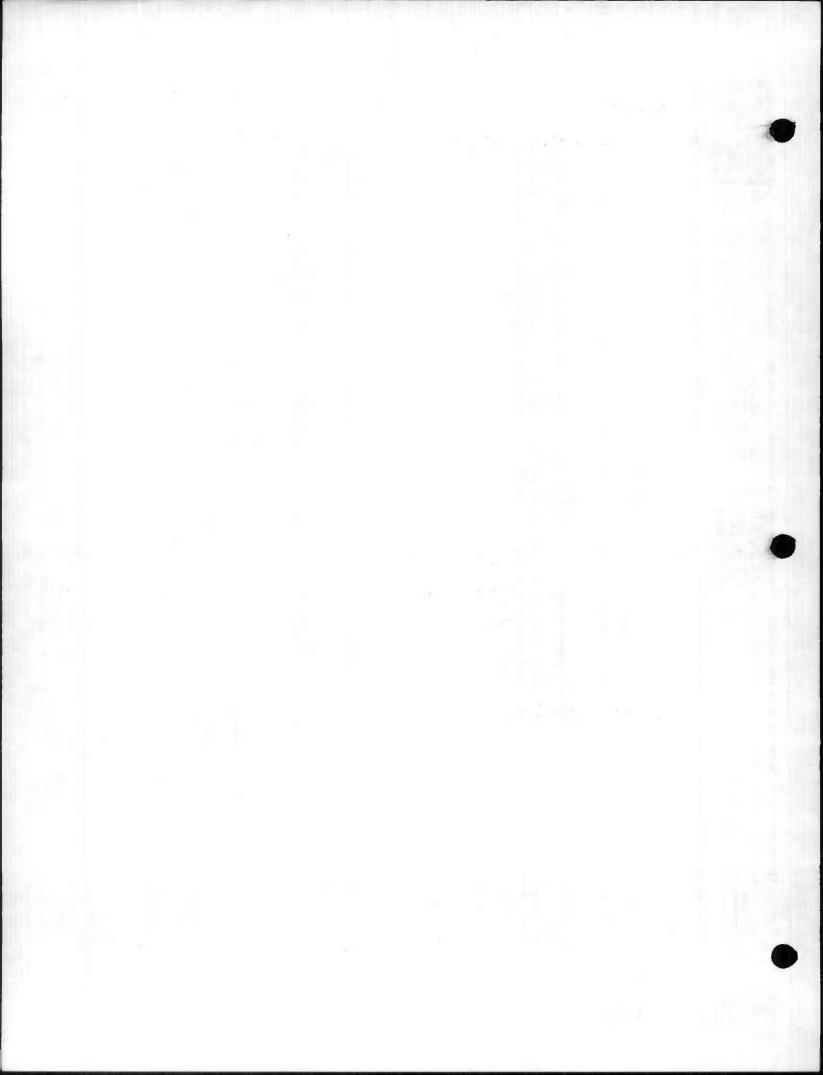
Colil

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

(Check only one)

Hopkins Hospital Haige C. Kilian Johns 32, Registrar's Signatura

was Davidson Brodelle



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2 Data of Death Jaw/s 2 Am June 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death General Hospital Ba 1to tallston Fallston 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 100M 20 F 423-48-0667 Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits Belair 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 210 1001 Glenangus Drive 4. 2 12. Was Decedant Evar In U,S. Armed Forcas? 1 XYas 2 No 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 🕱 No Black Specify: 3 DWidowed 4 □ Divorcad Year or Dates 15. Decedant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 50,001 Collaga (1-40r 5+) Hasta 4yrs - 2yrs Elamantary/Şacondary (0,12) Principal 12th grade 17, Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maidan Sumama) Kawls Dobbins Wilma Hanler 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) horaune Belain, Thornton - Daughter 1001 Md 21015 Glenangus 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) reenwood Montgomery, AL 21. Signature of Funaral Sarvice Licenses wabash 300 P. nt. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Immadiata Causa (Final disaasa or condition rasulting in daeth) CONGESTIVE HEART FAILURE 1 YEAR Dua to (or as a consequence of): Sequantially list conditions, if any, laading to Immadiata cause. Entar Undarlying Cause (Disaese or Injury that initieted events that initieted events rasulting in daath) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? RENAL FAILURE END STAGE 1 Yss 24 No 3 Probably 4 Unknown DUODENAL ULCER, BLEEDING 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 21 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axeminar? 26. Pleca of Death (Check only one) 1 Yas 2 No 1 Impatiant 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify)

Physician /Medical Examiner

the burial-tran this certificate Affer

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examinal must be notified at once.

Baltimore, Maryland 21215-0020

/Medical

10a. Stata

Funeral Director

Completed by

Physician/Medical Examiner Completed by Be 27. Manner of Deeth

Medical Certification: To

completely filled in by the To the Hospital within 24 hours a To the Funeral C

or Attending Physician:

Director:

)obbins,

3 Sulcida 4 Homicida 29e. Cartifian

1 Natural

2 Accidant

29b. Signatura and titla of certifiar

ANDROW

5 Panding Invastigation 6 Could not be detarmined

28b. Time of

28e. Pleca of Injury - At home, farm, streat, factory, offica building, atc. (Spacify)

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

D08096

28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

28d. Dascribe how injury occurred

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

den Nowaling um 30. Nama and address of parson who complated causa of deeth (Item 23e) (Type, Print)

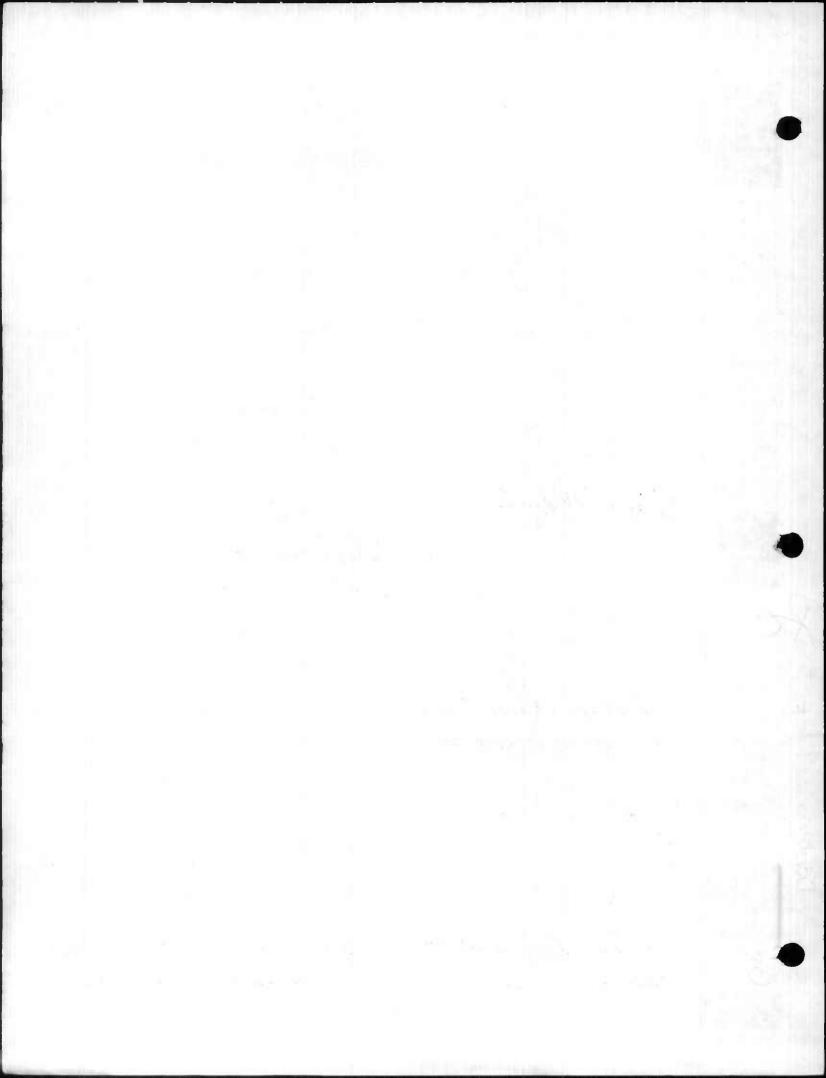
MD

JUN52, 1998 125 N. MAIN ST. BELAIR, MD 210/

State Registrar 31. Data filed (Month, Day, Yaar) JUN 0 4 1998

NOWAKOWSK 1 32. Registrar's Signatura

Juna Dandson-Randson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** 1998 7:12 DM MAT /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Baltmore 1001 If Under 1 Year Months | Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 M 2 F 62 261-46-6326 -10-1936 Usual Residence of Decedent 10e State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 No Baltimore Director Ma 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 2809 21215 Hvenue lano Funeral 13. Wes Dacedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11. Maritet Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give Yeer or Detes: Black, White, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Trucking Diamond Etementary/Secondary (0-12) College (1-4or 5+) uch Company 10th grade NA Driver 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 10e Levis more 19b. Meiling Address (Street and Number or Rural, Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) - Wife Baltimore, Mid enue larie 20b. Plece of Disposition (Name of camatary, crametory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete oshell (enetmy timore 4 Donetion 5 Dother (Specify) ne of Juneral Service Licenses Name and Address of Fecility 21215 Avenue Balto, Md 00 Prof.1. Enter the disease, or complications that caused the dileth. shock, or heart failure. List only one cause on each line. Do not enter the mode of dylng, such as cardiac or respiretory errast, Approximete Interval Between Onset end Deeth hypotension with circulatory Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): Examiner acidosis Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in daeth) Last perkalemi Physician/Medical 18 10MO Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert it. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably Completed by 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 8 26. Piece of Deeth (Check only one) examiner? examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpetient 3 DOA Menner of Deeth 28c. tnjury et Work? 28d. Describe how Injury occurred 28b. Time of 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner ettending physician and for use es the buriel-transit Box 68760that the deeth certificate be signed by the et requiras should has After this certificeta Division of Vital Physician: diractor, funeral Attending To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completaly filled in by the fu death.

Certification:

edical

Funeral

Director

7 is marked other than "natural", or Itama 23a or 28a-f show traumatic avant, the Modical Examinar must be notified at

the Marylend

death

72 hours after

filed withIn

pernit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic evant. the

Physician

/Medical

Maryland 21215-0020

State Registrar

31. Dete filed (Month, Day, Year)

JUN 0 4 1998

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 ☐ Homicide

6 Could not be determined

g) 23a) (Type, Print)

and menner stated.

28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify)

Butimore

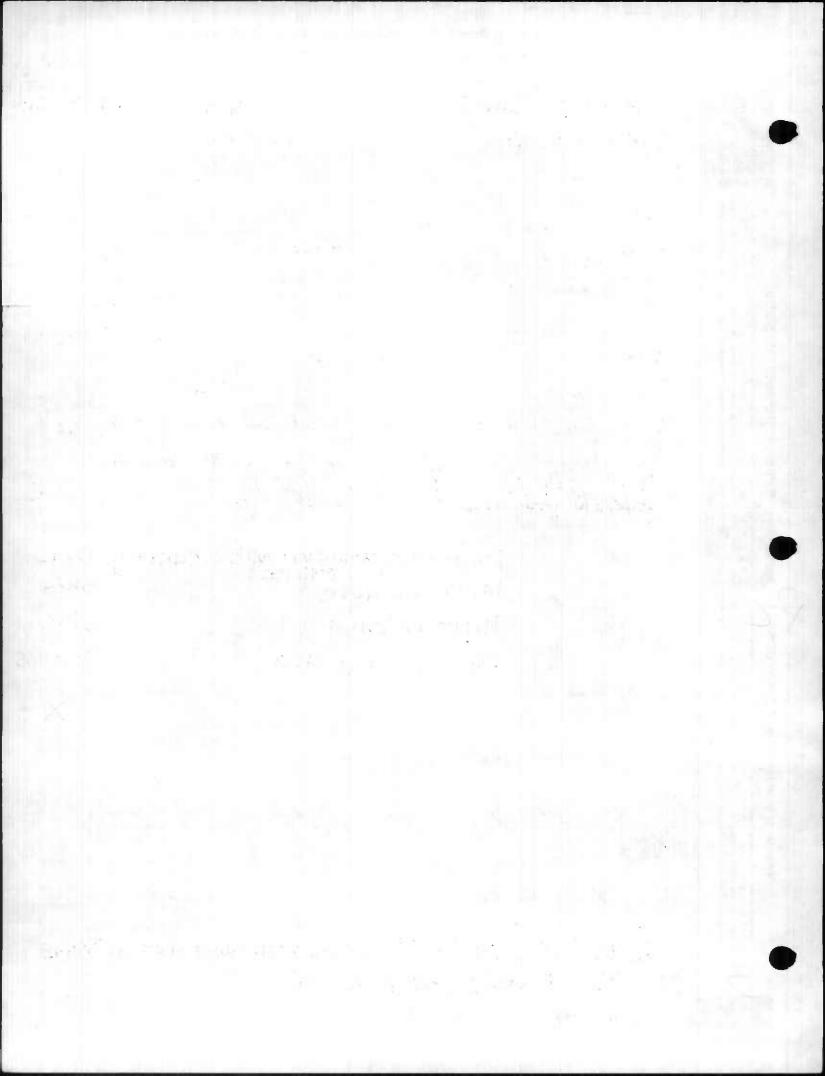
29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) and menner as stated.

2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pieca, and due to the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #7 Per FH Film G760 6-4-98rc 2. Dete of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:00 P.M. JUNE MARGARET E. ERVEN /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL ANNE ARUNDEL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 KF 88 Yrs. NEW JERSEY Director 145-10-7341 4/30/1910 Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mental hygiens, it is marked of the than "natural", or items 23a or 28e-f ehowing it flom 27 is a marked other than "natural", or items 23a or 28e-f ehowing or other traumatic event, the Mastice Esperition must be notified. 1 Yes 2 □ No Directo MD N/A BALTIMORE CITY 10e. Streef and Number 10g. Citizen of What Country? 10f. Zip Code 16 BON AIR AVENUE U.S.A. Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 | Yes 2 M No If Yes, Give Year or Dates: 14. Race - American indian, 11. Merifel Sfatus Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: WHITE þ 3 XXVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** FUNERAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JESSIE SMITH CHARLES JOHNSON 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM A. ERVEN. JR. - SON 16 BON AIR AVE., BALTIMORE, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Buriai 2 Cremation 3 Removel from State 4 Donation 5 ☐ Other (Specify) GREENGROVE CEMETERY 6/6 KEYPORT. NJ 21. Signature of Funeral Service Licenses RAYMOND C. FINK FUNERAL HOME OF GLEN BURNIE 426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061 Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate interval Between Onsef end Deeth **Physician** /Medical in mediate Cause (Final crease or condition roulting In death) LARDSEPS1S Examiner Due to (or as a consequence of): Examiner CEREBRO VASCUMAR BREWSENI physicien and the bunal-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): AMA Box 68760. FUS ALLATION Physician/Medical Due to (or es a consequenca of) USB BS signed by the a Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown COCONADU ADIEM D757732. Division of Vital Records. þ 24b. Were autopsy findings evallable prior to completion of cause of death? should should Completed 24a. Wes an autopsy s certificate hes l 1 Yes 2 No 1 ☐ Yes 2 ☐ No I or Attending Physician: effer death. Director: After this certifica director 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npafienf P 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury af Work? 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Piece of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral Di-completely filled in Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. Medicai 29e. Certifier To the 29d. Date signed (Month. Dev. Year) 29b. Signature and title of cartifier 29c. License number

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r's Signature which Deviden - Mandale

Oten Brown ms. 20061.

Pot person who completed cause of death (Item 23a) (Type, Print)

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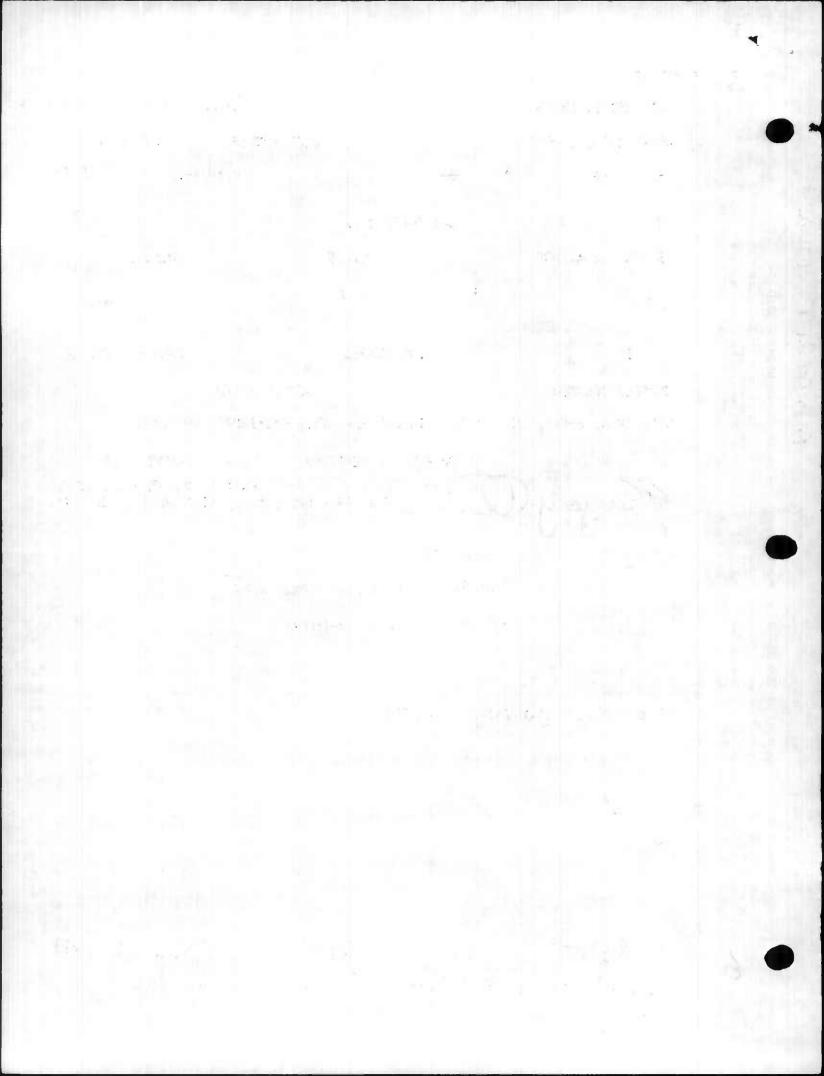
MARGARE

State Registrar 30. Name and address

Over on

JUN 0 4 1998

ed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 4a. Facility Name (If not institution, give street end number) treeman 4c. County of Death 4b. City, Town, or Location of Death Radimore If Under 24 Hrs. 8. Hours Min. OCCOURS HOSPIFUL 6. Sex 77. Ige (In yrs. last birthdey) Balimore C SON If Under 1 Yaar Security Number 9. Birthpleca (State or Foreign Months Devs MARYLAND 214-64-8197 Usual Residence of Decedant 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MARYLAND N/A BALTIMORE CITY 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 2921 BELMONT AVENUE 21216 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ ♠o If Yes, Give 13. Was Dacedent of Hispenic Origin? (Spacify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yes X No Specify: Specify: BLACK 3 Widowad 4 Divorced 16e. Dacadant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) FEDERAL HILL NURSING 12th grade NURSING ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MARY PEAY COLEMAN PEAY, SR. 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Mary Peay/ Mother 1210 Sherwood Avenue, Baltimore, Maryland 21212 20b. Placa of Disposition (Neme of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1) Buriai 2 Cremation 3 Ramovel from Stata KING MEMORIAL PARK 6-5-98 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Fugeral Sarvice Licensia 22. Name and Address of Facility WILLIAM C. BROWN COMM. FUNERAL H 1206 W. NORTH AVENUE 23a. Pert1. Efter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one ceusa on each line. Approximata Interval Between Onset and Deeth Myocandial Infarction tmmadlate Cause (Final disease or condition rasulting in deeth) heart Ischemic Sequantially list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Disease or Injury that Initieted events rasulting in deeth) Last Due to (or es a consaquence of) hypertensim Due to (or as e consequence of): 23b. Did tobacco use confributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tailure 24b. Wara autopsy findings available prior to completion of causa of death? 24e. Was an autopsy performed? 2 No 1 Yes 2 No 26. Plece of Death (Check only one)

Physician /Medical **Examiner**

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

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Funeral

Director

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Funeral Director

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Completed

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Pages 1 end 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. And the file and 23a or 28a-1 shownth: If time 27 is marked other than "natural", or Hems 23a or 28a-1 show any or other traumatic event, it is whosted in any to or other traumatic event, it is whosted in any or other traumatic event, it is whosted to any or other traumatic event, it is whosted to any or other traumatic event, it is whosted to any or other traumatic event.

21215-0020

Baltimore, Maryland

Box 68769

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Records,

Division of Vital or Attending Physician:

Hospital

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within 2 \$

Physician/Medicai Examiner

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funeral director, this 24 hours efter death. filled in by Medical

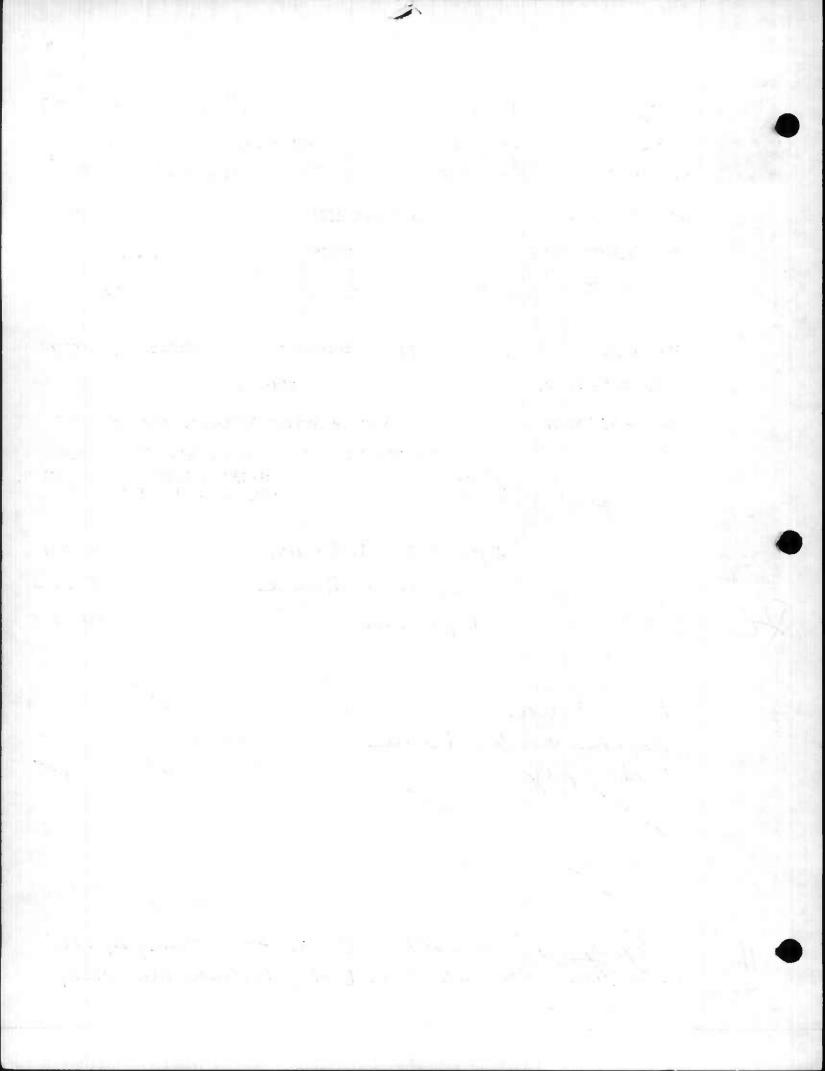
> State Registrar

Part II. Other significent conditions contributing to death but not resulting in the underlying causa given in Part I. Peripheral vascular diseare Cardiomyopathy 25. Was case rafarrad to medical exeminar? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. tnjury et Work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be dataminad 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 29a. Certifian 10 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and menner statud. 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifier June, 2, 1998

Blud, Baltimore MO 21239

Loch 5-601 Raven Lim 32. Ragistrar's Signature JUN 0 4 1998 which Deviden Randalle

30. Name and ridress of person who completed cause of daeth (Itam 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Foote lorence 1493 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death mem NIA HOSP. Union Baltimore If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. (Month, Day, 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign 10 M 20F 242-24-9114 Yrs. N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 HYES 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? St. E. 25th 401 W.S. A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - Amarican Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No fl Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Home Domestic unk 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Foote Jack ElizA Coleman 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Falls Rd, Batton MD Erdman Beverly 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Zion Bapt Ch. CEM Macon, N.C. 6-6-98 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funerai Sarvice Licensee E. North Ave 1101 F. H March ENST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Immediate Cause (Finat disease or condition resulting In death) Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributa to the causa of death? Ves 2□ No 3□ Probably 4□ Unknown 24a. Wes an autopsy 24b. Were autopsy findings aveileble prior to completion of causa of death? 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1□ Yes ZNo Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medicai

Examiner

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Director

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Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itel impiry or other traumatic event, the Medical Experient any Injury or other traumatic event, the Medical Experient.

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

Funeral

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Eli Zabeth to 2 After Attending

Be Completed by Physician/Medical

Medical Certification: To

29a. Certifier

To the Ha within 24 P To the Fur

State Registrar

27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred

1 Directoral 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

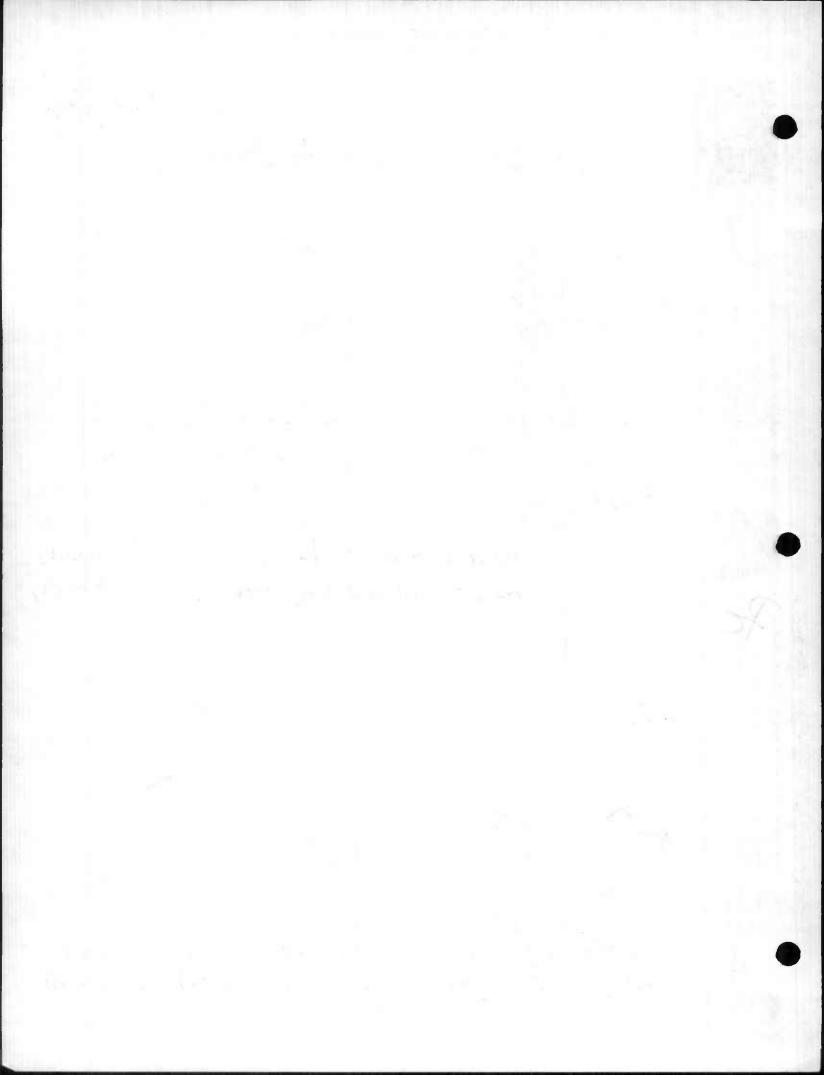
Certifying Phyeiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of cest 29c. License number

leted cause of deeth (Item 23a) (Type, Print)

menonial Hospital 37 House my 212TP 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Degedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Death Month **Physician** etta C RAVINEA 1998 5:45AM JUNE /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days Hours Min 1 M 200 Yrs MD Director 216-42-6086 85 NOV. 3, 1912 Usuei Residence of Decedent with the Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 THO Directo MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be 1 WOODHUE COURT 21133 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours efter death 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian Bieck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes XXNo Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. HOUSEWIFE OWN HOME 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be KOLKER EVA SILVERMAN PHILIP 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) of Health JUDY MANDELL (DAUGHTER) 3622 ANTON FARMS ROAD PIKESVILLE, MD 21208 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XX Burial 2 Cremetion 3 Removel from Stete important: If it any injury or o CHIZUK AMUNO ARLINGTON 6/4/98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name end Address of Fecility Sol Levinson & Bros., Inc. Man eun 8900 Reisterstown Road Baltimore, MD 21208 ie, or complicators that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only operations on each line. Approximete Interval Between Onset end Deeth Physician /Medical immediate Cause (Finet disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760 05/ Physician/Medicai signed by the a Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Whiknown 2 No p 24b. Were autopsy findings available prior to been si Completed 24e. Wes en eutopsy completion of cause of death? i certificate has t director, page 2 s 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after deeth. Poperal Director: After this certific funeral director, 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 19 Inpatient 2 ER/Outpetient 3 DOA Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1- Naturei 1 Yes 2 - No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number City or Town, Stete) 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homictde 1 Cortifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature and title of pertific 29d. Date signed (Month, Dey, Year) 29c. License number

woo completed cause of death (Item 23e) (Type, Print)

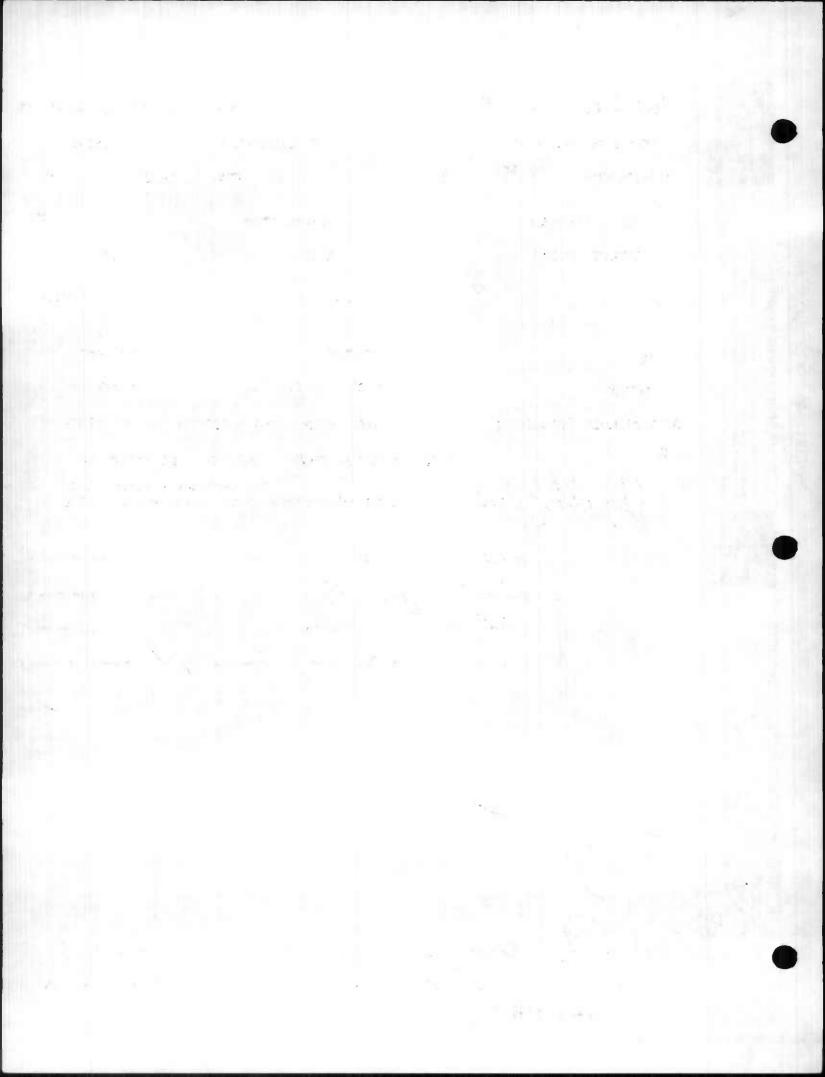
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State Registrar

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State of Maryland / Department of Health and Mental Hygiene

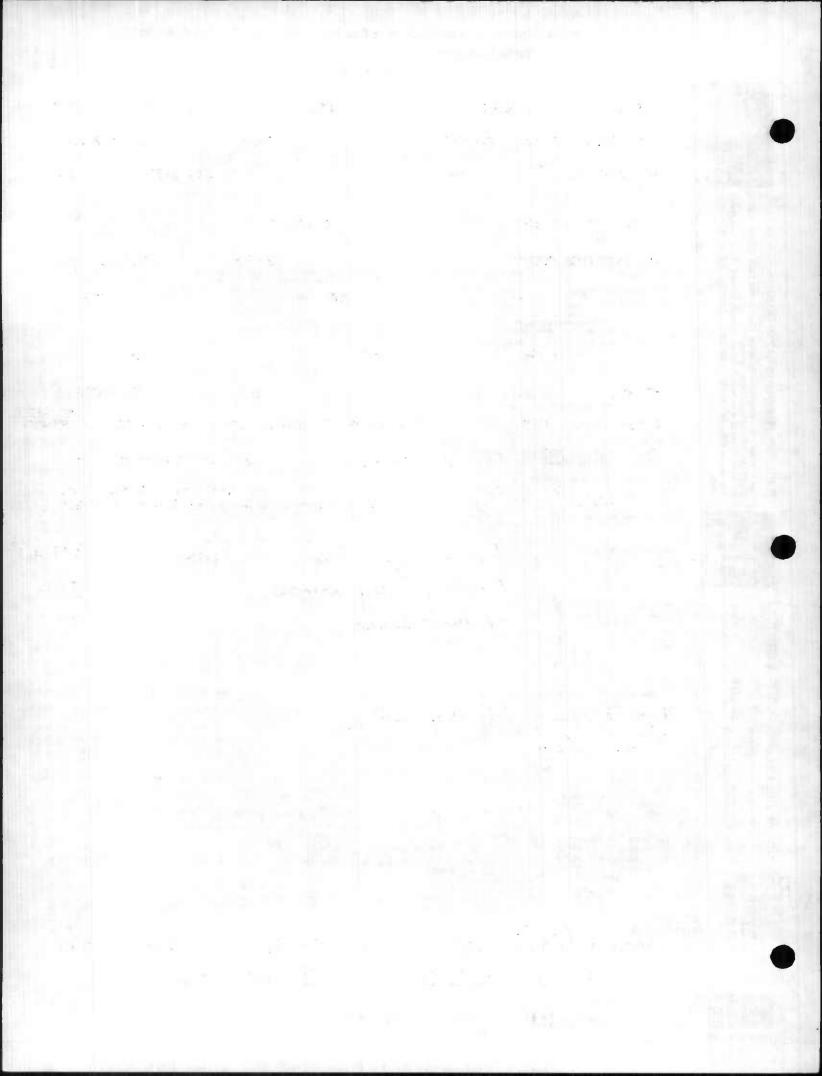
Certificate of Death 3. Time of Death 1 Decedent's Name (First, Middle Last) 2. Date of Death **Physician** JUNE 2, PHILIP HOWARD GOLD 1998 12:28 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONIGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 165-28-7948 64 JUNE 6, **Director** PA Usual Residence of Decedent the Maryland 10a. Sfafe 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1X Yes 2 No ecto MD MONTGOMERY ROCKVILLE 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours aftar death with. Department of Haaith end Mentel Hygiena. Important: If Item 27 is marked other than "natural", or items 23s or any injury or other traumatic event, the Wed call Example must be nonce. 급 4920 MELINDA COURT 20853 Funeral U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. No Yes 2 □ No Yes, Give Year or Dates: 1 Never Married Married 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use ratired) (Specify only highest grade completed) College (1-4or 5+) Elamantary/Secondary (0-12) LAWYER LAW 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be To HENRY SADIE ROSENBERG 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) MD 21201 19a. Informant's Name/Ralationship (Type, Print) BARBARA GOLD (WIFE) 1900 BLAUSTEIN BLDG., ONE N. CHARLES ST., BALTIMORE, 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation Removal from State 4 Donation 5 Othar (Specify) BNAI ISRAEL 6/4/98 GREENSBERG, PA 21. Signature of Juneral Servica Licensee 22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Baltimore, MD 21208
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, Approximata interval Batween Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Examiner Examiner physician end the buriel-transit daath certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a copaequance of) vero Scheroso Box 68760. Physician/Medical Due to (or as a consequence of): use as t 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 PYee 2 No 3 Probably 4 Unknown Thision of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate has b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Residenca 8 ☐ Other (Specify) 1 Yes 2 No Hospital: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA funaral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Aftar 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth. 2 Accident affer deet 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medicai (Check only To the To the Comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number June 2, 1998 28791 man w 30. Name and address of person who complated cause of death (Hom 23a) (Typo, Print)
616 Executive Volumes, Voc Cochrille 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Julia Davidson-Randalla JUN 0 4 1998 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 1998 Month **Physician** Joseph Marion Gugliuzza June 1, 10:28 AM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4103 Glenmore Avenue Baltimore 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Month Day Year)
10/20/1906 7. Age (In vrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1 N 2□ F Days Hours 91 Maryland 216-32-7870 Yrs. Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore Director 1 Ves 2 □ No N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4103 Glenmore Avenue 21206 U.S.A. Негля 23а Funeral 12. Was Decedent Ever In U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. should be filed within 72 hours after ond Mental Hygiene.

marked other than "naturel", or item 1 ☐ Yes 2 ☐ No It Yes, Give X Yeer or Dates: 1 Never Married 2 Married 1□ Yes 2□ No Specify: White by 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) School School permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygin important: If Item 27 is marked any injury or other the page. School Teacher 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Salvatore Gugliuzza Concetta Sabatino 19a. Intormant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9148 Throgmorton Rd. Baltimore, Maryland 21234 Salvatore J. Gugliuzza 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Commation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/2/98 Laurel, Maryland Balto./Wash. Crematory 22. Nama and Address of Facility Dippel Funeral Home Inc. 21. Signeture of Funeral Service Licensee 7110 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or comshock, or heert tailure. List only death. Do not enter the mode of dylng, such as cardiac or respiretory errest Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical neumania Examiner Dur 16 (or as a consequence of Physician/Medical Examiner S Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): Due to (or as a consequenca ot): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings evaileble prior to completion of cause of death? Completed 24e. Was an autopsy performed? page 2 certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29e. Certifler Medicai 🗷 Certifying Physician: To the best ot my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner es steted. Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print) rancis mann, 31. Date tiled (Month, Dey, Year)

State Registrar

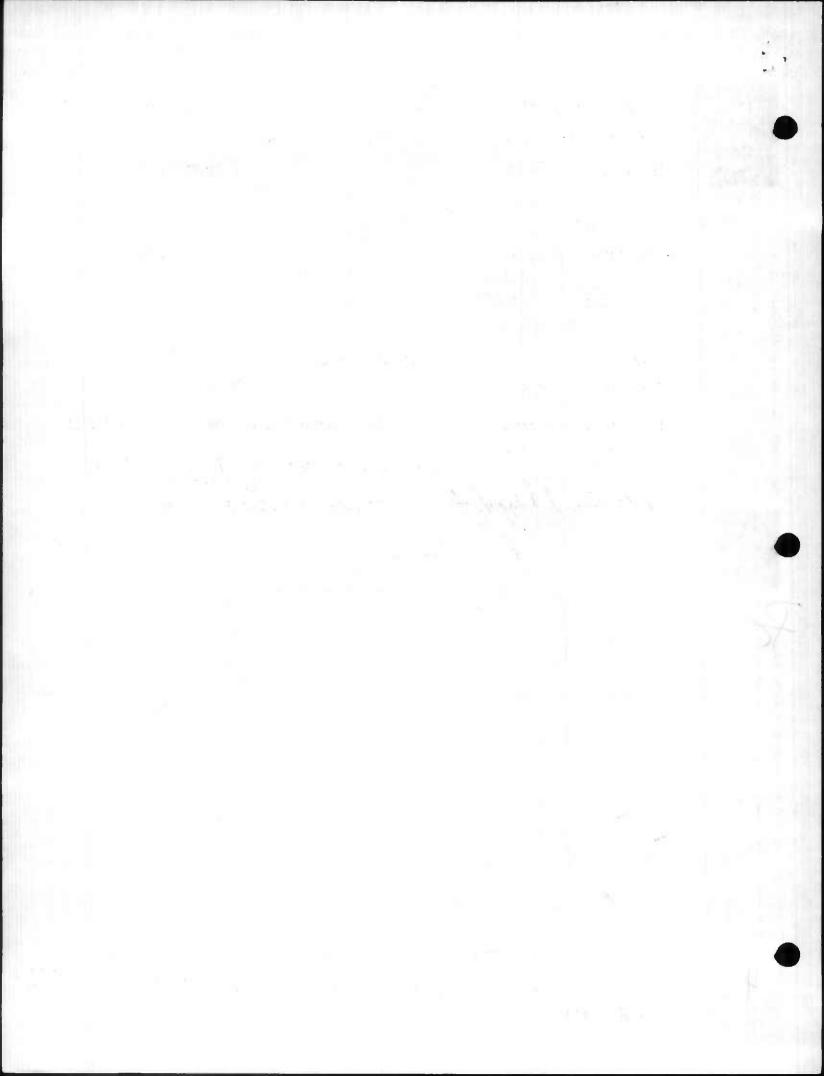
JUN 0 4 1998

death

Baltimore, Maryland 21215-0020

Records, P.O. Box 687

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month OAM **Physician** ELIJAH ARKIS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner BALTIMORE Mount 23 NIA If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Dey, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 10 M 20 F Yrs. 215-22-1148 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No NIA Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 21217 MOUNT USA STREET Funeral filed within 72 hours after death 12. Wes Decedent Ever In U,S. Armed Forces?

1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Marital Status Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementery/Secondery (0-12) College, (1-4or 5+) MARYLAND 12 TH ANDLER GRADE NIA 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Hill Important: If Item 27 is marked oth any Injury or other traumatic even CURRY VIOLA LUCIAN HARRIS 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) AVE. #A3 HARRIS DAUGHTER BALTO. MO. PAMELA 1521 MADISON 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State GARRISON FOREST 6-10-98 UWINGS MILLS, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses Funeral Ser vice Balto. 5151 NatL. 1301 to. M.D. 21229 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arresphock, or high adjure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Stage Liver Disease /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner PRESUMED HEPATO CELLULAR CARCINOMA Physician/Medical Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last eno carcinoma of Skin (metastatic) Box 68760 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably Division of Vital Records, P. NIA p 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Work?

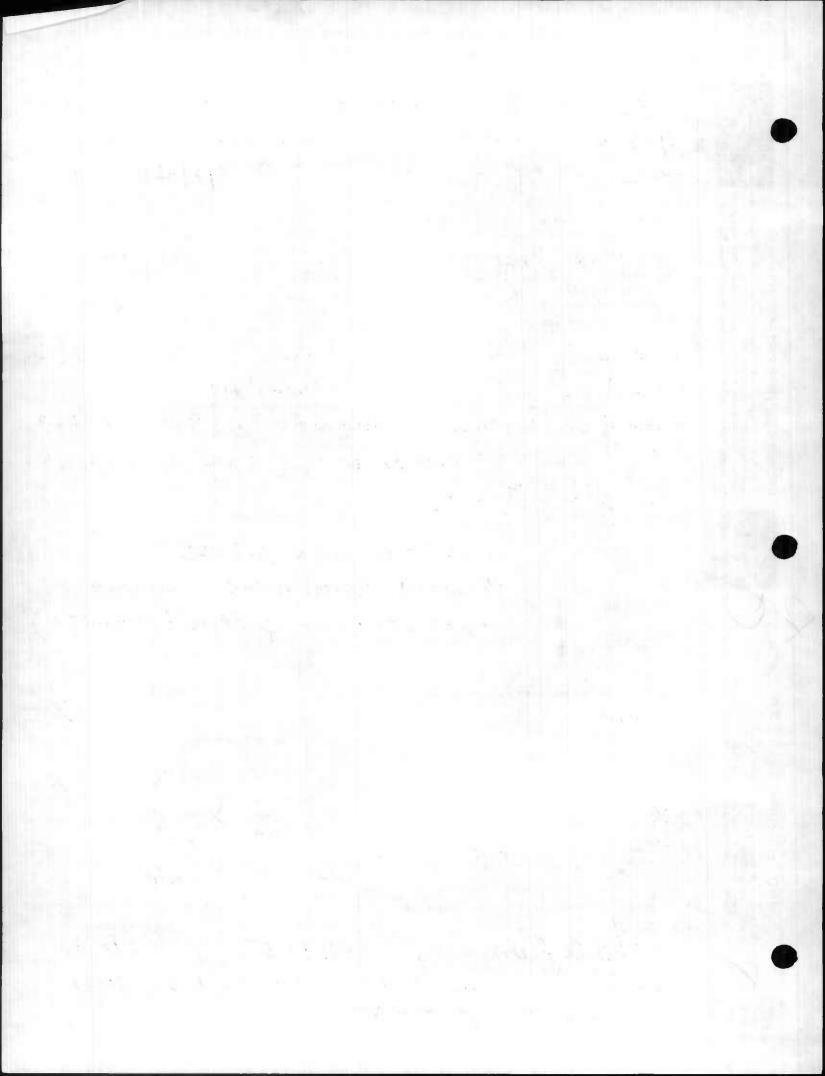
1 Yes 2 No 28d. Describe how injury occurred Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) 2 1 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA B.R. 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation Attending NIA Director: 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide o de To the Hospital
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completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number man mi of death (Item 23a) (Type, Print) BALTIMORE, MI) South

32. Registrar's Signature.

Hima Navidson Aandelle

DHMH 16 Rev 6/95

Registrar



98-3090-510 CMK HAZEI G. HARRIOTT

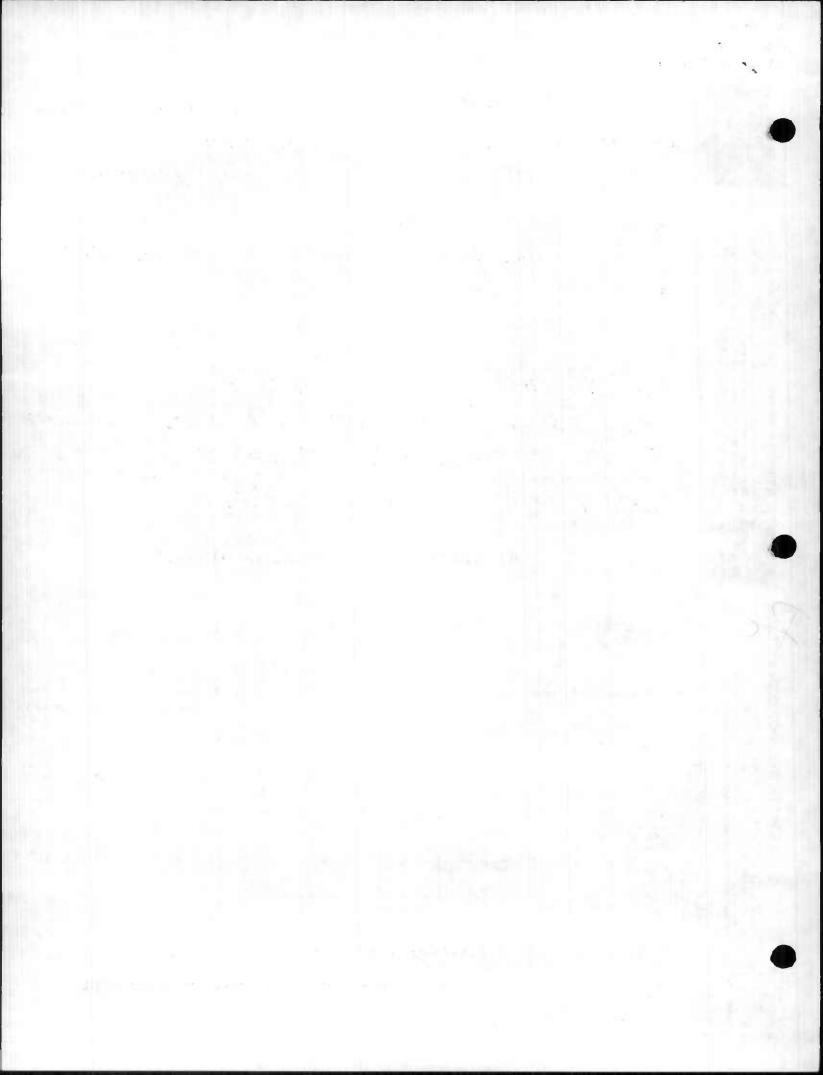
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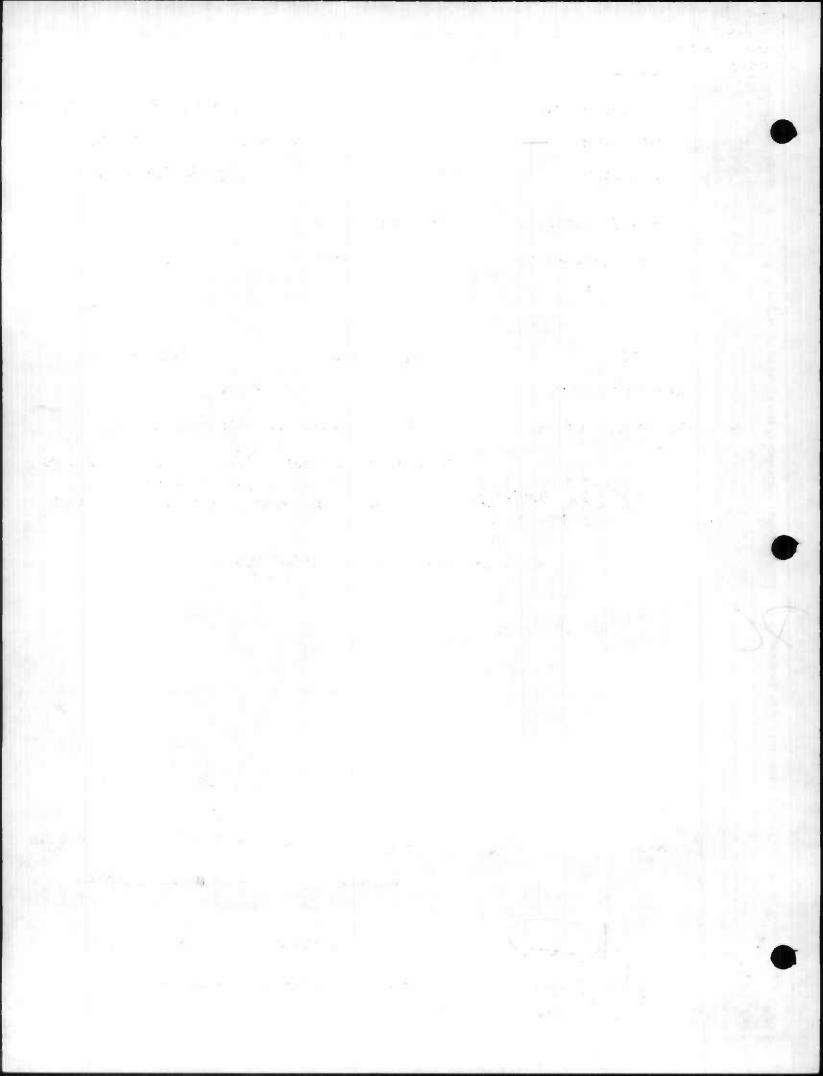
State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death

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Regist	rar	JUN 0 4 199	b Jun	minimization								

Registrar

JUN 0 4 1998





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** Month /Medical 4a. Facility Neme (If not institution 4b. City, Town, or Location of Death Examiner more Social Security Numb If Under 1 Yaar If Undar 24 Hrs 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foraign Country) **Funeral** Months Days Yrs Director Usuel Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at Director 1 Yas 2 No 10f. Zip Coda 10g. Citizan of What Country? ò 816 items 23a Funeral Was Decedent Ever Armed Forcas? Race - American Indien, Black, Whife, etc. 11. Marital Status 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) permit. Peges 1 and 2 should be filed within 72 hours etter a Department of Heelih end Mental Hygiene. Important: If Item 27 is marked other than "netural" ---- any Injury or other traumetic expense. 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Married 2 Married 1□ Yas 2 No by 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. pDO NOT use ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Mother's Nama (First, Middla, Maidan Sumama) 01 17. Fathar's Nama (First, Middla, Last) ONAN 19b. Meiling Addrass (Street and Number or Rural Routa Number, City pr Town, Steta, Zip Coda) OCHERN, MD & 20c. Location - City or Town, State da 21201 20b. Placa of Disposition (Nama of cematery, crematory or other place) 20e. Mathod of Disposition 1 A Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service License cations thet causad tha death. Do not antar the mode of dying, such as cardiac ona causa on aach lina **Physician** /Medical Immediate Causa (Final disaasa or condition rasulting in daath) **Examiner** Physician/Medical Examiner The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enfar Undarlying Cause (Diseese or Injury that initieted evants rasulting in daath) Last physician ers the burial-fr Records, P.O. Box 68760. Dua to (or es e consequance of): nse. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? YO¥ 2□ No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Was an autopsy performed? page 2 s MIA certificate 1 ☐ Yas 2 X No 1 ☐ Yas 2 ☐ No of Vital 25. Was case rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 1 Yas 2 XNo Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Othar (Specify) Mannar of Death 28b. Tima of 28a. Date of Injury (Month, Dev Year) 28d. Dascribe how injury occurred 28c. Injury ef Division 5 Panding invastigation 1-ENatural 1 ☐ Yas 2 🗷 No H 2 Accidant 6 Could not be 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, farm, streef, factory, office building, atc. (Specify) 4 ☐ Homicide within 24 hours
To the Funeral
completely fitted 29e. Cartifiar 1 Certifying Physician: To the best of my knowladge, deeth occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. Medical

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and menner stated.

Hormas

29c. Licensa number

744001 II

29d. Deta signed (Month, Day, Year)

State Registrar

(Check only one)

29b. Signetara and titla of certifian

31. Data filed (Month, Dey, Yaar)

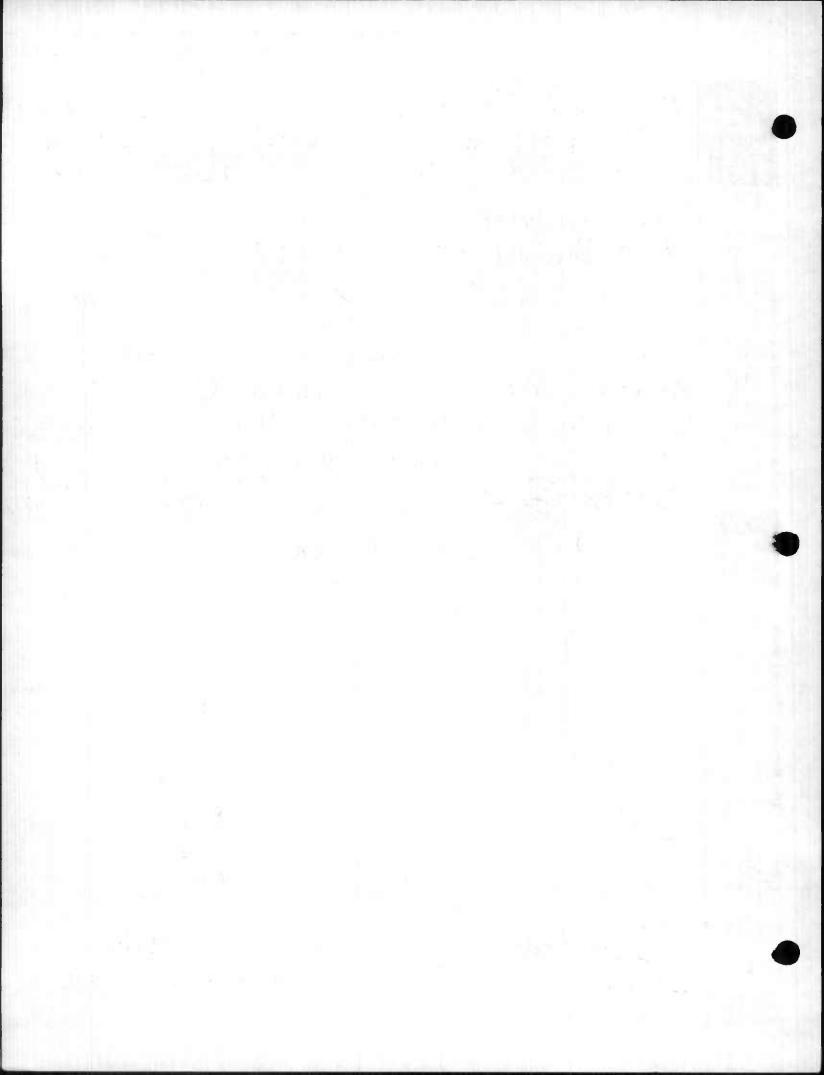
W/414

Nama and addrass of person who complated cause of death (Item 23a) (Type, Print)

OHIO

32 Registrar's Signatura

Sa Davidson



State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month GRACE E. KING JUNE 2, 1998 7:35 P.M. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner KNOLLWOOD MANOR NURSING HOME MILLERSVILLE ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Birthplace (State or Foreign Country) 1□M 2⊠F Deys 241-50-4304 95 Yrs. Director JULY 5, 1902 PENNSYLVANIA Usuel Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL ARNOLD 1 ☐ Yes 2 🖾 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1144 FERBER AVE. 21012 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marltel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Illed within 72 hours after Hygiene. Wher then "neturel", or the 1 ☐ Yes 2 🖾 No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) SECRETARY CLERICAL permit. Pages 1 and 2 should be tile.
Department of Health and Mental Hy, important: If them 27 is marked other any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be CHARLES W. LAPP LAVINIA (UNKNOWN) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) LOIS M. PLUMMER / DAUGHTER 20191 E. COUNTRY CLUB DR., APT. 2709 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete JUNE 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Denetion 5 □ Other (Specify) GLEN HAVEN MEM. PK. 5, 1998 GLEN BURNIE, MARYLAND e of Funeral Service Doensee 21. Signatu 22. Name end Address of Fecili KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E, GLEN BURNIE, MD 21061 23a. Pert1. Emiliar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset end Deeth **Physician** /Medical Immediete Cause (Final artery disease diseese or condition resulting in deeth) Examiner physician and s the burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting In deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 StUnknown aubything Dementia Records, þ 8 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Medical Certification: 28b. Time of 28d. Describe how Injury occurred After t 28c. Injury et Work? After death. Hospital or Attending 24 hours after death. 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) John, MD JUNE 3, 1998

PO-SHIU HUNG, M.D., 1916 CRAIN HWY., SUITE 8, GLEN BURNIE, MARYLAND 21061

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

John Davidson-Randall

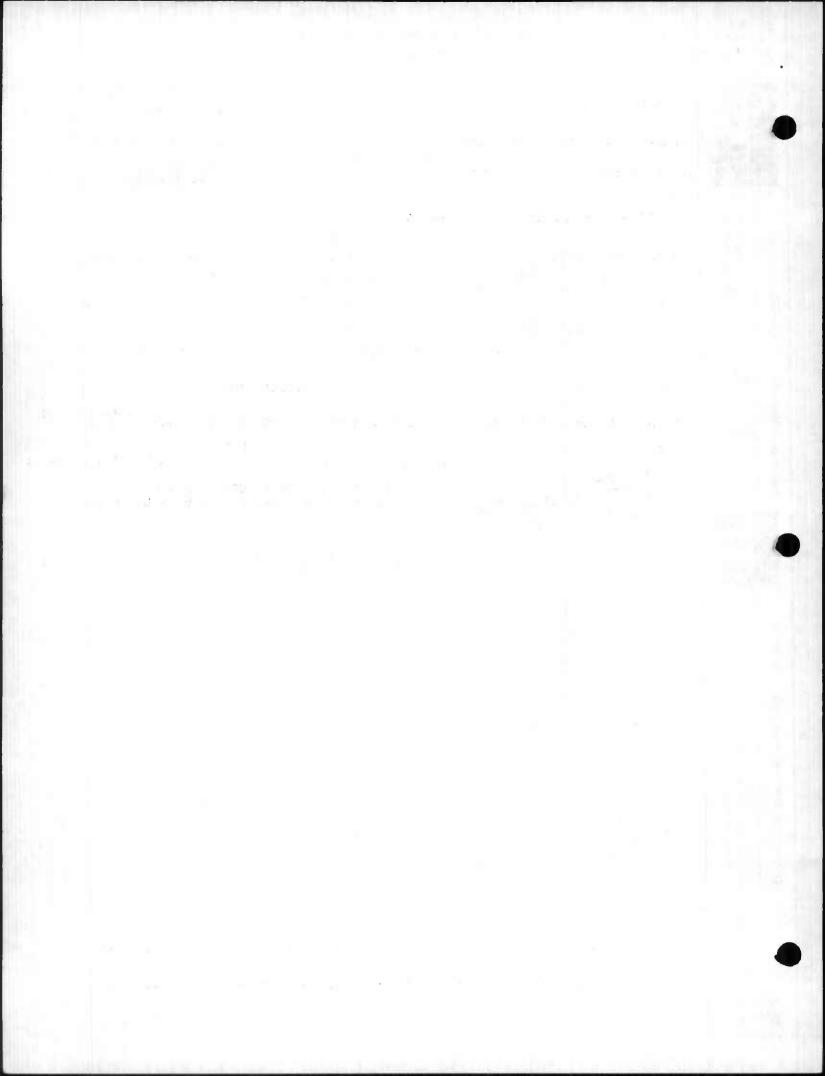
31. Dete filed (Month, Dey, Year)

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State

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 11.16 PM. Physician June 1998 atricia 2 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number, Examiner North Arundel HOSPital Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 8 | 9. Birthplece (Stete or Fore Country) | Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 212 F 59 Yrs. 191-30-2214 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, tre Medical Examiner must be incurred as Maryland Anne Arundel Severn 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7817 Elberta Drive 21144 United States death Funeral 14. Rece - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 T Married 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 'naturel'. Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Veterinary Hospital 4 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) 2 should be fi and Mental H is marked of Be Margaret Fabian George Mautino 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i Theodore P. Lecorchick 7817 Elberta Dr., Severn, MD 21144 Itimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) June 5, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of F 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from State injury or Catonsville, Maryland Department Important: H Metro Crematory, Inc. 4 □ Donation 5 □ Other (Specify) 1998 22. Name and Address of Facility 21. Signature of Funeral Service Licens Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E, Glen Burnie, MD 21061 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one cause on each line. Approximate Interval Between Onsel end Deeth Physician Overlam Cancer /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Failure -IVer Werk certificata be axecuted physician and the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): as 950 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown failuresigned b Remail Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy completion of ceuse of death? page 2 hes 2 No 1 ☐ Yes 2 No 1 Yes certificate or Attending Physicien: funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Don inpetient 2 ER/Outpetient 3 DOA 2 this 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined To the Hospital or Atterwithin 24 hours after der To the Funeral Directo completely filled in by the 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end manner stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Shey Elassal, June, 2, 1998 D 51400 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Arundel Hospital 301 Hospital Drive Glen Burnie, no 21061 Sherib Elassal. North

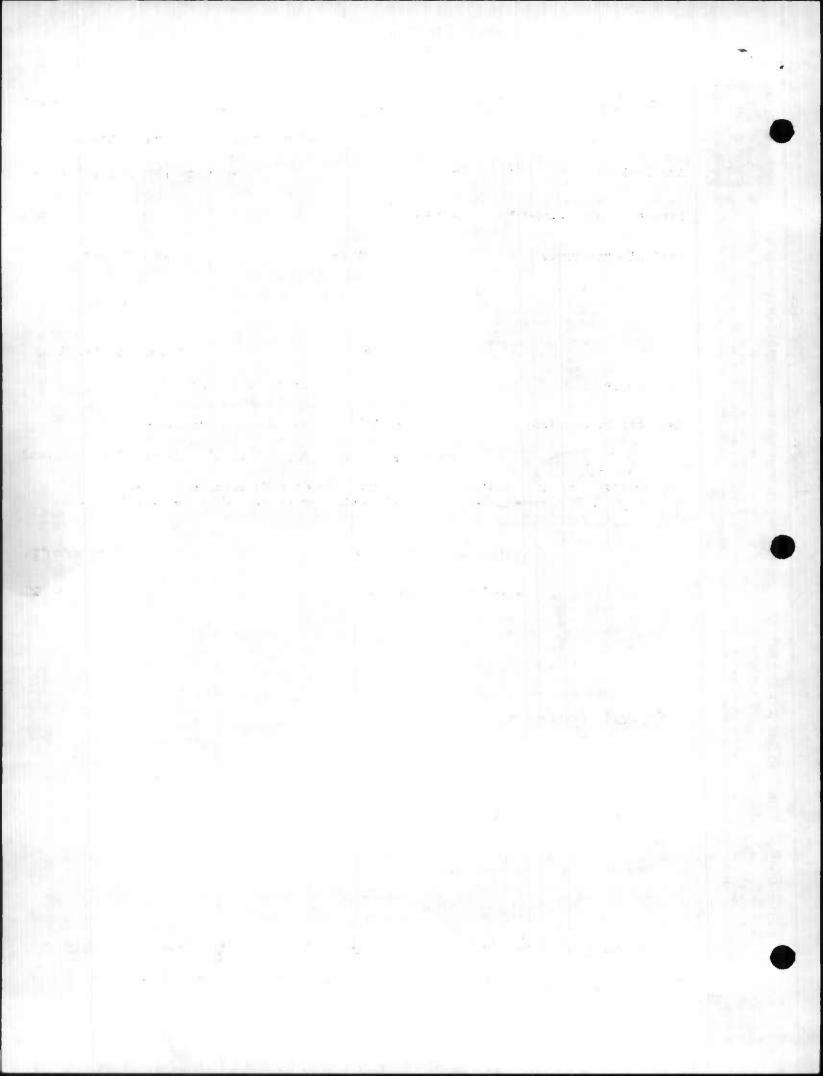
State Registrar 31. Dete filed (Month, Dey, Year)

JUN 0 4 1998

32. Registrar's Signeture

Patricia

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dafa of Deeth 3. Time of Death **Physician** June 1:00 am /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) County of Death Examiner ranklin If Undar 1 Yeer 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex Aga (In yrs. last birthday) **Funeral** 108M 20 F Months Days Hours Min Yrs. Director 236-12-9471 09/30/1920 Ohio Usual Rasidance of Decedant Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiens. 10c. City, Town or Location 10e Steta 10b. County 10d. Insida City Limits r 28a-f show show 1 Yes 2 No MD Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 7 is marked other than "natural", or items 23a or traumstic event, the Medical Examiner must be 1 5707 McCormick Avenue 21206 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 □ Yes 2 □ No If Yas, Giva Yeer or Detes: 14. Rece - Amarican Indian, Black, Whife, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 Never Married 2 Married Specify: White 1 Yas 2 No Specify: þ 3 Widowad 4 □ Divorcad Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest greda complated) Elementery/Secondary (0-12) College (1-4or 5+) Supervisor Sears Appliances 12 18. Mothar's Neme (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Be John Raymond Loman Eunice Wade 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. informant's Name/Ralationship (Type, Print) of Health a John B. Loman 1103 Yorkshire Way Westminister Maryland 21158 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata important: If it any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 0aklawn 6/6/98 Baltimore, Maryland 21. Signatura of Funaral Sarvica Licensea 22. Nama and Addrass of Facility Dippel Funeral Home Inc. 23a. Part1. Entar tha disease, or complications that caused the court. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximents and Court of the c Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examine Examiner MIC Sequentially list conditions, if eny, laeding to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting In death) Lest Dua to (or as a nemuc Physician/Medical The law requires that the death certif Division of Vital Records, P.O. Box signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 3 Probably 1 ☐ Yss 2 ☐ No þ 24b. Ware eutopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? s certificate has t 2 No 1 ☐ Yas 1 ☐ Yas 2 ☐ No or Attanding Physician: funeral director. Be 25. Was case referred to medical axaminar? 26. Plece of Deeth (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 € ER/Outpetient 3 ☐ DOA 2 After this 28c. Injury at Work? 27. Mennar of Daath 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred Certification: 1 Natural 2 Accidant 5 Pending after death. Director: Aft 1 Yes 2 No invastigation 6 ☐ Could not be detarmined 3 Sulcide 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide filled in 24 hours a Hospitai Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the causa(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invasfigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical completely (Check only one) To the F 29b. Signature amy title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) mson m

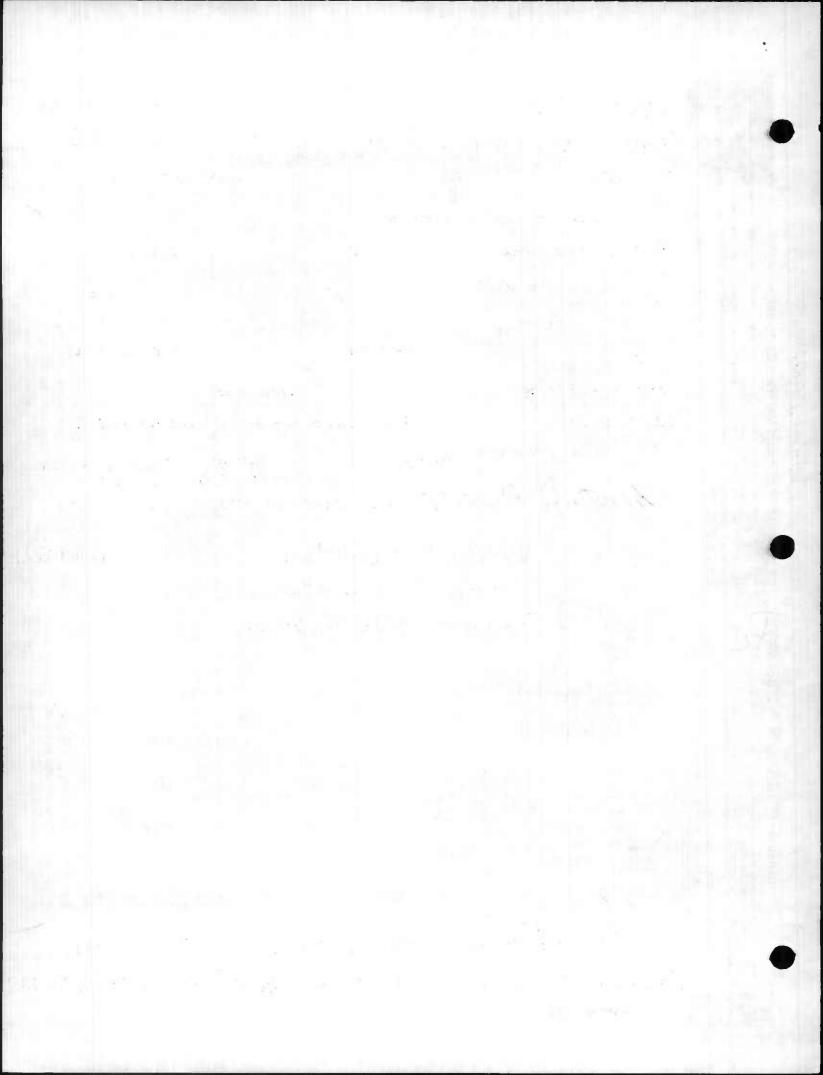
State Registrar

31. Data filed (Me

30 Name and address of person who completed causa of daath (Item 23e) (Type, Print)

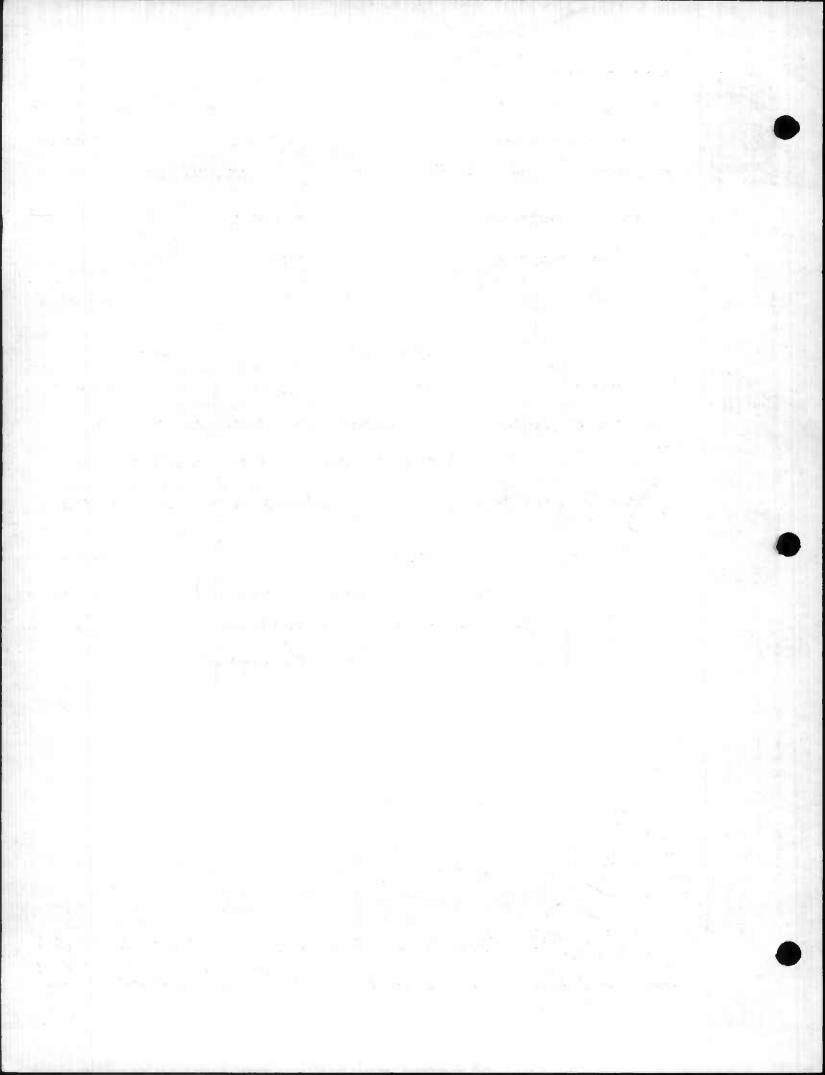
32. Registrar's Signature

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Amend: #1	Od F	Per FH Film G760 6-4-		Maryla		artment of I <i>rtificate of</i>		d Mental Hy	giene Reg. No.	98	17338	
/Med	1. Decedent's Name (First, Middle, Last) Physician /Medical Examiner 4a. Facility Nama (If not institution, give street and num.							2. Data of De Month Suve	Day 2_ (4	Year 198	3. Time of Death	
Exami Funeral	ner	NORTHWES 5. Social Security Number 6	rer	If Undar 1 Yaar	RAND	ALLSTOWN Hrs. 8. Date of Bin	th	В	BALTIMORE Birthplace (State or Foreign Country)			
Director		217-78-4138 Usual Residence of Decedent	1□ M X X F	8	33 Yrs.	Months Days	Hours N	Ain. (Month, Da	y, Year) 4, 1914	Coun	MD	
he Maryland 28a-f ehow	Director	10a. State 10b. County 10c. C MD BALTIMORE 10e. Street and Number			ity, Town or Lo	1000	PIKE	SVILLE		10d. Inside City Limits 1XX Yes AND		
d 21215-0020 filled within 72 hours after death with the Maryland thygiene. ther than "naturel", or frems 23s or 28s-f show int, the Medical Evanines must be norithed at	Funeral Dir	5 PEACHTREE COURT 11. Marital Status 1 Never Married XXMarried 1 Yes 20 No			J.S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexicen, Pue			(Specify Yes or No	U.S.A 14. Race	a - Americ		
215-0020 thin 72 hours af e. an "neturel; or Med cal Exern	Completed by	3 Widowed 4 Divorced Year or Datas: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			1 ☐ Yas ZZNO Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)			Specify: WHITE rorking 16b. Kind of Business/Industry				
and 21215-0 be filed within 72 ho ital Hygiene. or other than "netur ovent, the Med call.	Be Com	17. Father's Name (First, Middla, Last)			HOUSEWIFE 18. Mother's			Name (First, Middle,	OWN F	-0.2		
Maryland 2 d 2 should be filed th and Mental Hygi T is marked other traumatic event, i	ToE	PHILIP 19a. Informant's Name/Relationship (Type, Print)			JACOBS MOLL:			IE LEVIN Rural Routa Number, City or Town, State, Zip Code)				
re, N s 1 and 3 Health tem 27		CHARLES MACKS 20a. Method of Disposition XXBurial 2 Cremation 3	☐Removal from Si		Place of Dispo	ACHTREE sition (Name of natory or other pla		PIKESVIL	LE, MD 20c. Location -	2120 City or To	~	
Baltimo permit. Pages Department of Important: If It eny injury or once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lic		HE		RIENDSHI . Nama and Addre	ess of Facility	Sol Levin		os.,	Inc.	
Physician /Medical		23a Lum Enter the disease, or co	mplications that cally one ceuse on each	-9	th. Do not enter	er the mode of dyl	Reister ng, such as cer	stown Road	d Baltin rast,		Approximate Interval Between Onset and Death	
The law requires that the death certificate be executed to have been signed by the attending physician and page 2 should be detached for use as the burial-transit	an/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. b. Re. c. HisT	Due to (or as a consequence of a consequence of a conseque	uence of): Full uence of): uence of):	1.	Recent? Trow ease			mknowd unknowd	
es that the designed by the a	by Physician/M	Part II. Other algnificant conditions	contributing to dea	th but not res	sulting In the ur	derlying ceuse gi	ven in Part I.				the cause of death?	
ne law requires the has been signed go 2 should be to	Completed I				_			perfo	an autopsy med?	SVE	era autopsy findings ailable prior to mpletion of causa death?	
OT VICAL MOPYSICIAN: The latter that the certificate harral director, page	Be	25. Was cese referred to medicel examiner?	Hamital	,				Death (Check only o		1	Yes 2 No	
Phys ral di	ation: To	1 Ves 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident Investigat	on		28b. Time of Injury	28c. Inju			lome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred)	
DIVISION pitel pr Attending purs after death. prayDirector: After	Certification:	3 Suicide 6 Could not determine	oma, farm, street, factory, office fy)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
The Park is	ledical	29a. Certifier (Check only (Check only and manner as stated.) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.										
23.28	2	29b. Signature and title of certifier	me	29c. Licansa number 5 o 45 4 tem 23a) (Type, Print) Tuy 5401 Old Coun			29d. Date signed (Month, Day, Year) Z/1998		
,2		30. Name and address of person who	completed ceuse	of death (Iter	n 23a) (Type, 1	ol old	Count	Road.	Randel	liston	21133 N/MD	
Sta Regist		31. Date filed (Month, Day, Year)		istrar's Signa								

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #xxxPen FH Film G760 6-4-98RC 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 05 **Physician** 0707 Monroe-Anne /Medical 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** NA Hospital Batimore na If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6 Sex 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months 218-36-1501 -8 Yrs. Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In: If Item 27 is marked other than "natural", or items 23e or 28e-f show 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow NA 1 Yes 2 No Battimore Ma Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or itema 23s or traumatic avent, the Medical Examiner inset being Huenne 3748 nela 21215 Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 ☐ Yes 20 No Baltimore, Maryland 21215-0020 Specify þ Slack 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) (leaners seams tress 12th grade 3 years 18. Mother's Neme (First, Middle, Maiden Sumeme) Fether's Neme (First, Middle, Last) Be NaoHI heorge Washington . Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bryant Washington 3748 Dolfield - Son Avenue Baltimore, Md 20c. Location - City or Town, Stete 20e. Method of Disposition 20b. Plece of Disposition (Neme of Dete permit. Peges
Department of
Important: If it
any injury or o Buriel 2 Cremetion 3 Removel from State ematin atonsulle, ma 4 ☐ Donetion 5 ☐ Other (Specify) 21215 21. Signeture of Juneral Service Licenses Name and Address of Facility West 4300 wabash Balto, My the mode of dying, such as cerdiec or respiretory erres that Enter the disease, or conshock, or heart tailure. List only polications that caused the death. Do not enter Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of) Division of Vital Records, P.O. Box 66160. thet initiated events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 1 → Yes 2 No 3 Probably 4 Unknown RCINOMA à 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy Completed is certificate hes director, page 2 20010 1 Yes 1 □ Ves 2 □ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 2 this funerai 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Naturel To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29d, Date signed (Month, Dev. Year) 29b. Signeture end tille of o 29c. License number

CREENE TREE

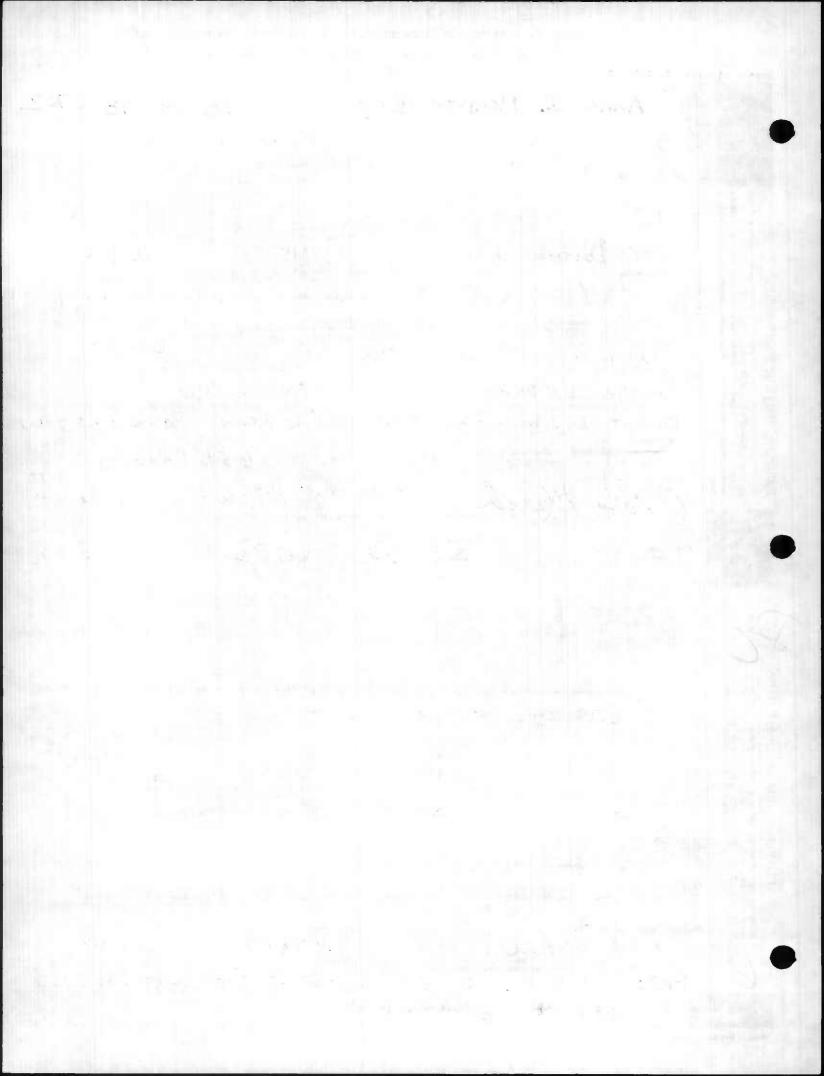
Registrar

State

31. Date filed (Mont)

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

32. Registrat's Signeture



98-3093-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

MARV

State of Maryland / Department of Health and Mental Hygiene 9 🔉 Certificate of Death

Days

3. Time of Death

10:57P.M.

1.8 71/1	
MEALS	

1. Decedent's Name (First, Middle, Last) Mary Kathryn Meals 2. Date of Death Month 01,

1998

4c. County of Deeth

Physician /Medical Examiner

4304 MIAMI PLACE 5. Social Security Number

219-56-7012

4a Facility Neme (If not institution, give street and number)

1 ☐ M 2 X F

If Under 1 Year 7. Age (In yrs. last birthday) 78 **Vrs**

BALT IMORE 8. Date of Birth (Month, Day, Year, 2/4/1920 Min.

4b. City, Town, or Location of Deeth

JUNE

 Birthplace (State or Foreign Country) Pa.

10d. Inside City Limits

Onset and Death

24b. Were eutopsy tindings available prior to completion of cause ot death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No

Funeral Director

Usual Residence of Decedent 10a. Stete MD Director

Funeral

Aq

Completed

with the Maryland Show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

el Hygiene.

filed within 72 hours efter Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: if Itam 27 is marked oth any Injury or other traumatic event page. **Physician**

/Medical **Examiner**

Examiner

Physician/Medical

by

Completed

Be

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Certification:

edical

29a. Certifier

pue as the 950 detached signed by 9 page 2 should need certificate hes After this funeral

State Registrar

certificate be or Attanding efter death. illed in by To the Hospital o within 24 hours of To the Funeral DI completely

68760

Records,

Division of Vital

10c. City, Town or Location n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4304 Miami Place 21207 USA Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 2 No If Yes, Give Never Merried 2 ☐ Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) **6th** Coilege (1-4or 5+) DISABLED Disabled 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Raymond E. Meals Mary C. Schwenk 19a. Intormant's Neme/Relationship (Type, Print) brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29517 Dutchmans Lane, Easton, Maryland 21601 Kenneth R. Meals 20b. Place of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, State 20e. Method of Disposition Burial 2 Cremation 3 Removal from State 6/5/98 Baltimore, Maryland Oaklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Joseph N. Zannino Jr. Funeral Hm. 21. Signature of Funeral Servica Licensee 263 S. Conkling St., Baltimore, Maryland 21224 Maria 23a. Part 1. Enter the disease, or concrications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finel Seizure disease or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

25. Wes case reterred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 □ Nursing Home 5 X Residenca 6 □ Other (Specify) 1 No 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, street, factory, offica building, etc. (Specify) 4 | Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one) 29b. Signature end title of certifier

29c. License number

29d. Date algned (Month, Day, Year)

MO

JUNE 2,1998 O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

24a. Wes an eutopsy performed?

INSPECTION

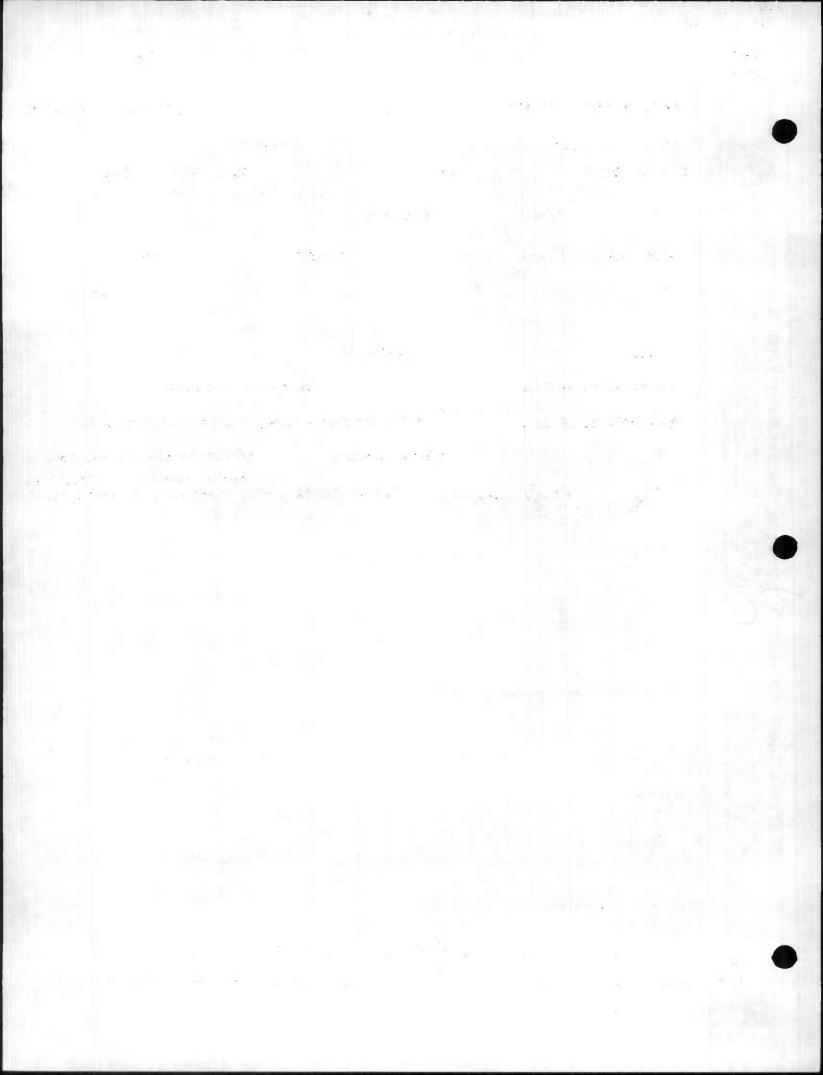
1 ☐ Yes 2 ☒ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Radentz, M.D. 31. Date tiled (Month, Day, Year)

JUN 0 4 1998

32. Registrar's Signature who Devidson-Randalle



32. Registrar's Signature

Felia Davidson

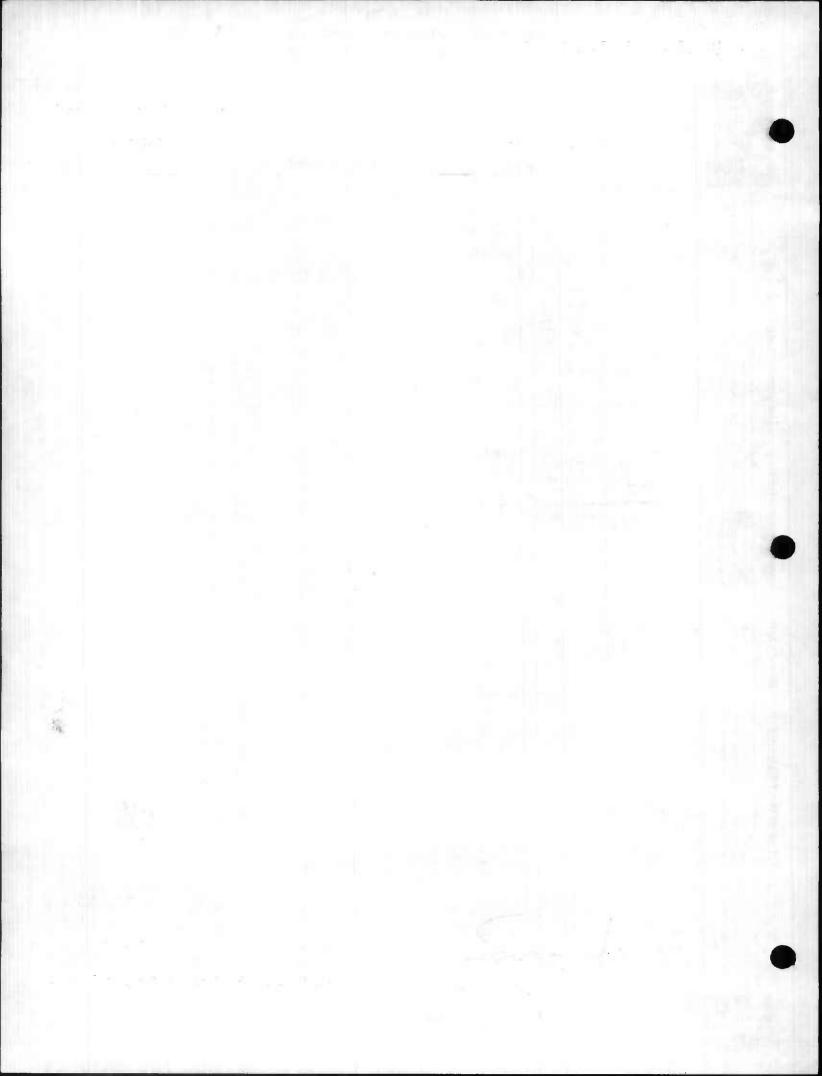
Mandall

Registrar

State

31. Date filed (Month,

JUN 0 4 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death MULLINS CARL VUNE 1998 02 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore City Good Samaritan Hospital If Under 1 Yaar if Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpleca (Stata or Foraign Country) № M 2 🗆 F Hours 74 Yrs. 405-22-4509 Jan. 5, 1924 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Pikeville Pike Kentucky 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41501 United States 120 Cedar Creek Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ty∏Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify White WWII 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Businass/Industry (Specify only highest grade complated) Elementery/Secondary (0-12) College (1-4or 5+) N/A Disabled in Service Years 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Becky Potter Noah Mullins 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justice Funeral Home P.O. Box 2290 Pikeville, KY 41501 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Mullins Cemetery 6/7/1998 Pikeville, KY 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 sa, or bumplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximete Interval Between Onsat and Death Immediete Cause (Final disease or condition resulting in death) in farclin Sequentielly list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Examiner

Physician/Medicai

p

Completed

Be

2

Medical

29b. Signature and title of certifier

Physician

/Medical

Examiner

10a. State

Director

Funeral

by

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Expression result to notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercises and December 1

Baltimore, Maryland 21215-0020

with the Maryland

death

g 28 signed by d be detact peed page 2

certificate has Attending Physician: director. 94 Affer

Division of Vital Records, P.O. A Hospital or Atta.

* hours after death.

* Director: A** To the Hospital within 24 hours a To the Funeral D

State Registrar 25. Was case referred to medical 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, famh, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier ta Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, deta and place, and due to the cause(s) and manner stated.

29c. Licensa number

11401

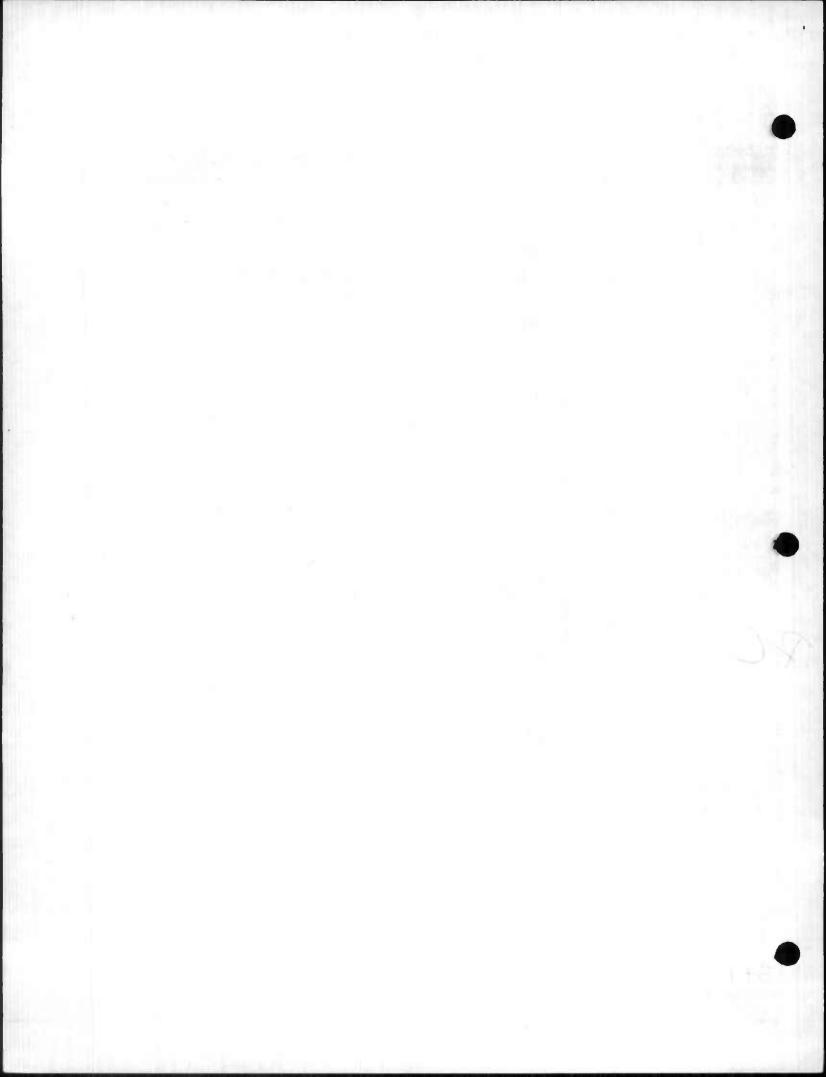
SOOI LOCH RAVEN BLVD.

29d. Date signed (Month, Day, Year) 1998 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EL. MERHI FADI

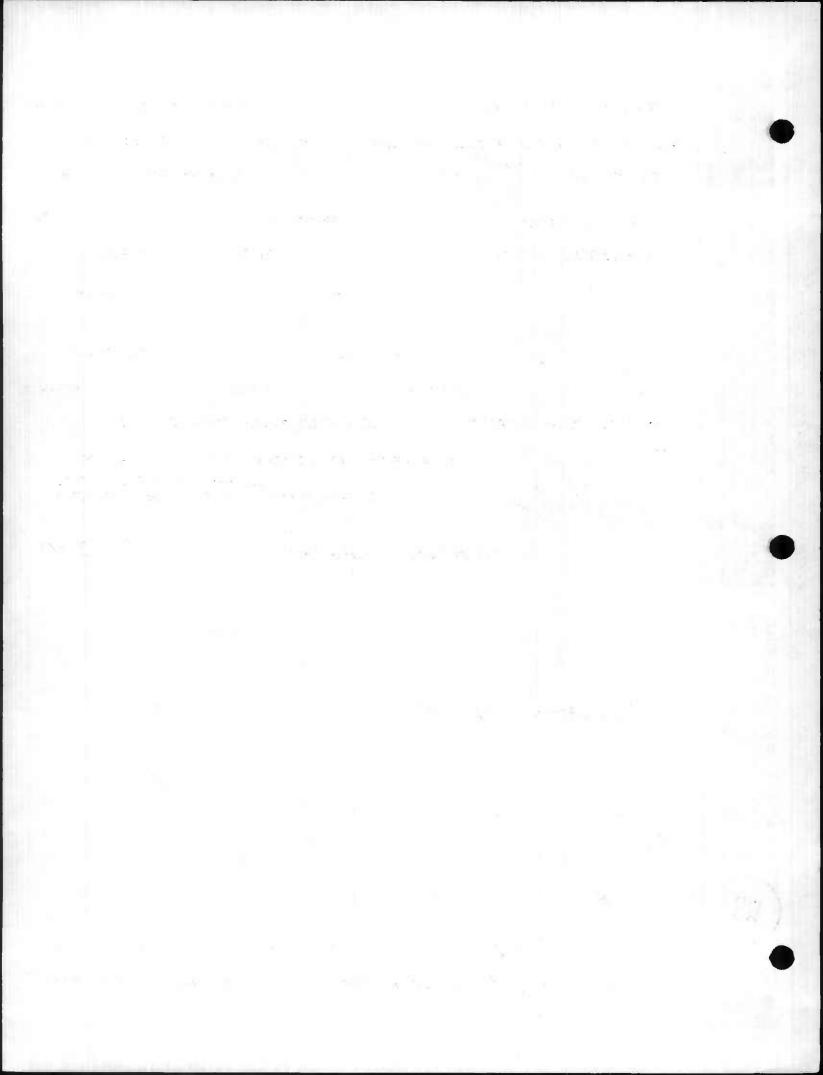
BALTIMORE 2 1239 M.D.

31. Date filed (Month, Dey, Year) 32. Registrar's Signature whice Davidson



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					Certifica	ate of	Death		Reg. No.) [1343
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and and		County		10c. City, Tow	n or Location					10	d. Inside City Limits
or 28a-f show be notified at	MD E	BALTIMOR	E				LTIMORE				1 ☐ Yes 🏋 No
		URST AV	ENUE		10f. 2	Zip Code	212	218	10g. Citizen of V	Mat Count	lry?
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marked o	DONALD			SIRASKY				RIAN			SCHWART:
PEE	19a. Informant's Name/Ra	lationship (Type,	Print)	19b	. Mailing Addre	ss (Stree	t and Number or Ru	iral Routa Numb	er, City or Town,	State, Zip	Code)
27 27 pr tr	DOUGLAS N	ESTOR (HUSBAND)	44 HO	MEHU	RST AVENU	JE BALT	TIMORE,	MD 2	1218
T P P	20e. Method of Disposition 1 Burial 2 Crem 4 Donation 5 0	etion 3 Rem	novel from State	cemete	f Disposition (A ry, crematory o	r other pla	Z CHAIM)	Date 6/4/98	20c. Location	,	
permit. Pages Department of Important: If its any injury or o	21. Signature of Funeral S			ANOILL					nson & B		
Ded ded ded ded ded ded ded ded ded ded	Jour 1	lau I	سنرد		8900	Reis	terstown	Road Ba	altimore	, MD	21208
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State	31. Dete tiled (Month, Day	Vear) 0 4 1998	32. Registr	ar's Signatura							
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Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Clark Nixon LOWIS 31 8:30 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** Ballmore HOSP Union MEM If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 10M 20F 80 N.C. 262-20-8068 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinat must be notified at MD NA Baltimore 1 TYS 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 Ceci 1 ALR 2621 W.SA Funeral death 14. Rece - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Specity: Black 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Stee Beth Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Laborer grade 7th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event Nixon Alexander minnie Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Ba Ho. 2 MD 21218 Callie Cecic Ave, Nixon 20b. Plece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cametery, crematory or other place) Baltimore, MD 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore con 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Lica ee 22. Name and Address of Facility 1101 E. North Ave Bernard F. H. THST march mound 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final my cordue disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last Due to (or as a consequenca of): Physician/Medicai Due to (or as a consequence of): Part II. Other elgnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown signed by à 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy Completed has 1 Yes 2 No 1 Yes 2 No bouned certificate Division of Vital Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 1⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 0 1 Yes 2 No this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred After or Attending Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely lilled in by th 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

Michaela 31. Date filed (Month, Day, Year) JUN 0 4 1998

29b. Signature and title of certifier



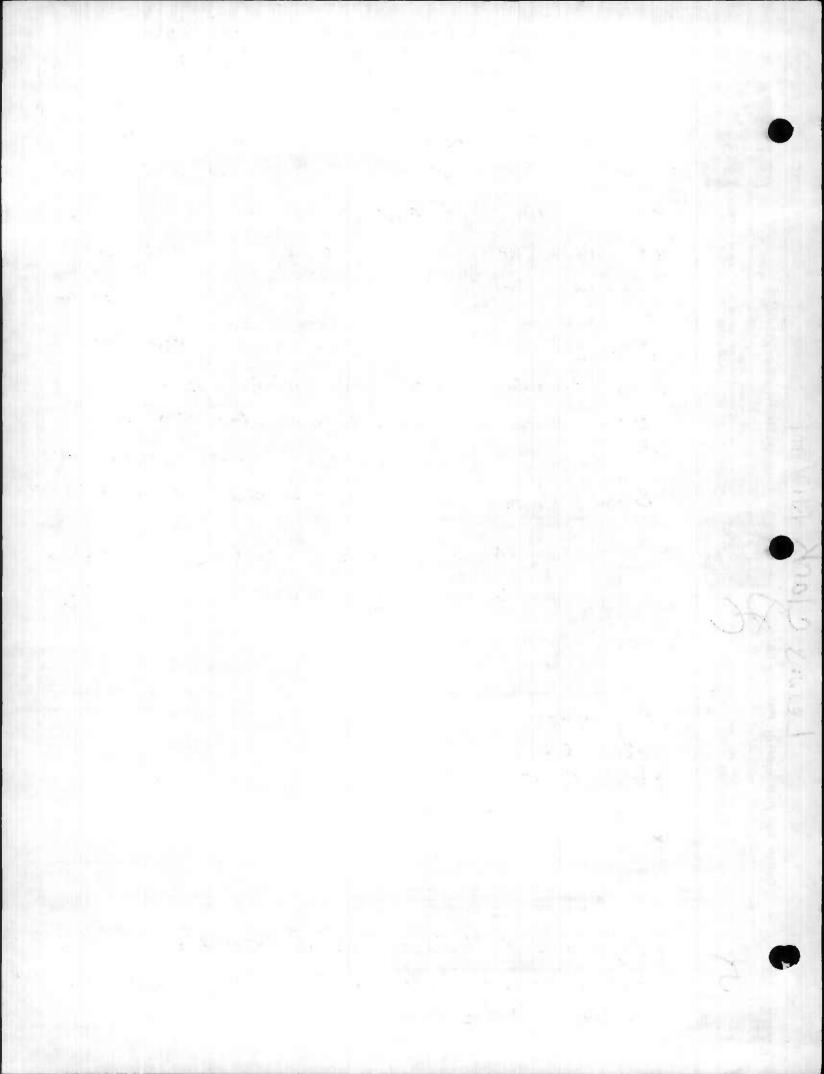
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

29c. License number

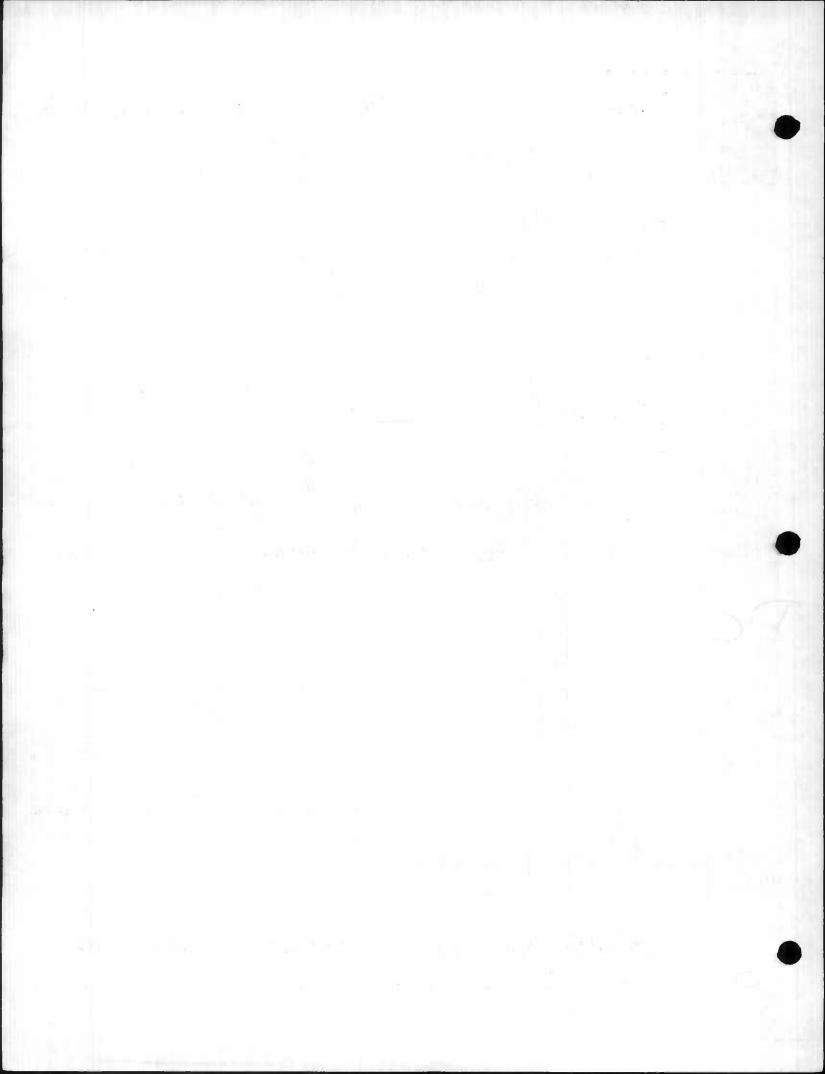
AT 243 89 46-M18

Union Memorial Hospital

29d. Date signed (Month, Day, Year)



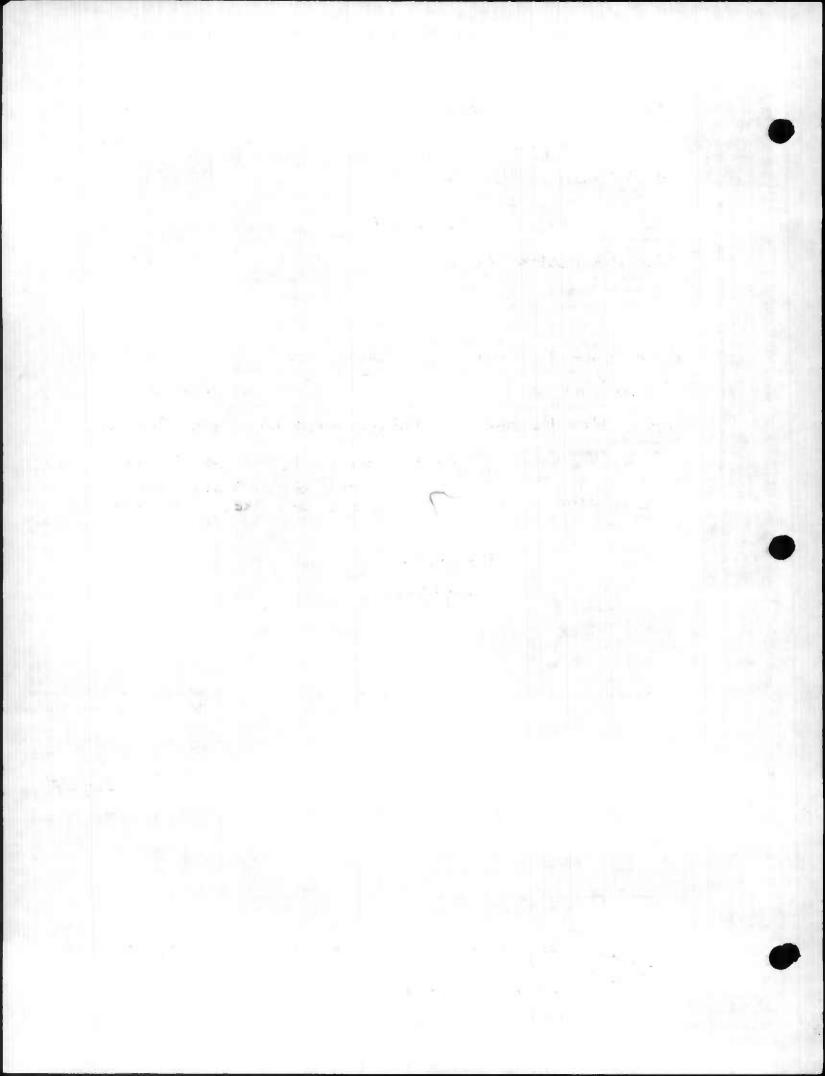
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	Examin Funeral Director		015-00-080	T. Age (In yrs.	. last birthday) If U	Under 1 Yaar nths Deys	0 .1	Nore 8. Dete of Bi	th 4c. County	
	ath with the Maryland 23s or 28s-f show	ctor	Usuel Residence of Decedent 10a. Stete 10b. County M. A. N. I.		ity, Town or Location					10d. Insida City Limits 1 Yas 2 □ No
	th with th	Funeral Director	10e. Street end Number 2821 Baker	Street	10	of. Zip Code	-16		10g. Citizen of V	vhet Country?
020	or items	by	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever In L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detas:		Decadent of His , specify Cuber as 2 No	spenic Origin? (S , Maxicen, Puer Specify:	Specify Yes or No to Ricen, etc.)	14. Rac Bled Specify	e - American Indian, ck, White, etc.
21215-0020	72 net	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondary (0-12)	cation e completed) College (1-4or 5+)		Usual Occupa of work do ne di OT use retired)	tion uring most of wo	rking	Johns Hos	Hopkins
Maryland 2	should be filed nd Mental Hygid marked other imatic avent, to	To Be C	17. Father's Neme (First, Middle, Last) Benjamin Ho	ff			Cora	hee	Maiden Sumem	(e)
Baltimore, Mar	other trau		19a Informant's Neme/Reletionship (Ty RON and OL, W.) 20a. Method of Disposition 1 Buriel 2 Cremation 3 GR 4 Donetion 5 Other (Specify)	er - Husband	Pleca of Disposition metery, cremetory	(Neme of y or other plece	aker	Date	1	City or Town, Steta
Baltin	permit. Page Department of Important: If any Injury or		21. Signeture of Funurel Service License	March	Mar	ne and Address	H. Wa	bash	Owing Avenu	e Balto, nd
	Physician /Medical Examiner	ı	23e. Print. Ental the diseesa, or complishock, or heart feilure. List only or Immediate Cause (Final diseasa or condition resulting in death)	Royal		Care			irrest,	Approximete Intervel Between Onset end Death
80,	beleasouled bura fransit	al Examiner	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury	Due to (d	or es e consequence	a of):				
Box 687	death certificate e attending private for use es the	an/Medic	thet initiated events rasulting in deeth) Lest	Due to (c	or es e consequence	e of):				
P.O.	thet the ed by th detache	y Physician/M	Pert II. Other significant conditions con	tributing to death but not res	sulting in the underly	ring cause give	n in Pert I.			ntributa to the cause of death? 3 Probably 4 Onknown
Records,		Completed by	/					24a, Wes	en eutopsy ormed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
Vital R	ysician: The lav s certificate has director, page 2	Be Con	25. Wes case referred to medical				26. Piece of De	1 □ eth (Check only		1 ☐ Yes 2 ☑ No
of	iling Ph After th funeral	၉	examiner? 1 Yes 2 No 27. Menner Death 1 Neturel 5 Pending investigation	lospitel: 1 Inpatient 2 Inpatient 2 Se. Dete of Injury (Month, Dey Year)	ER/Outpetient 3[28b. Time of Injury	DOA Othe	r: 4 Nursing H	lome 5 Res	idenca 6 doth	V
Division		Certification:	3 Sulcide 6 Could not be determined	28e. Pleca of Injury - At h building, etc. (Special	fy)			City or To	wn, Steta)	er or Rurel Route Number,
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	edical	29a. Certifier 1	elcian: To the best of my kno ner: On the basis of examine end menner stated.	owledge, death occu etion end/or investig	etion, in my op	e, dete end plece Inlon, deeth occu	e, and due to the urred at the time,	cause(s) and me dete end plece,	enner as steted. and due to the cause(s)
	To th To th Comp	M	29b. Signeture end title of certifier.	Q. 4. 1)	29c. Licensa	number Cars		29d. Date signer	d (Month, Dey, Yeer)
	3		30. Neme end eddress of person who co	mpleted cause of deeth (Iter		00	8900	R. W.	no 1	7//778
	Sta	ate ar	31. Date filed (Month, Day, Year)	32. Registrer's Signa		cutae	UST,	Ba No	Md	<1201



State of Maryland / Department of Health and Mental Hygiene 6

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0e	. Street and Nu	ımber			10f. Zip Code			10g. Citizen of \	What Countr	ry?
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	1 Naver Man	riad 2 Married	1 TYes 2		/		o rican, etc.)	Blac	CK, VVIIIIE, E	IC.
	3 🗆 Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:		1∐ Yes 2⊠ N	o Specify:		Specify		K
-		15. Decedent's Ed	ucation	16a. Dec	cedent's Usual Occ	cupation		16b. Kind of B		
-		cify only highest gra	de completed)	(Gi	ve kind of work dor . DO NOT use reti	ne during most of wor ired)	king	11		
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	Va	now	C -11,			NATL' PI	KE B	ALTO. M	0. 2	
	23a. Part1. Enter	the disease, or comp ert fallers. List only o	dications that cause one cause on each li	d the death. Do not a ine.	anter tha mode of o	lying, such as cardia	or respiratory	arrest,		Intarval Between
										Onset and Death
	Immediate Cause diseasa or condition	(Final	Hea	278, 1+00.						
1	rasulting In death)		a		sequence of):				1	
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1	rasulting in daath)	Last		Due to (or as a cons	equenca or):					
			d							
F	Part II. Other signi	ificant conditions co	entributing to death b	out not resulting in the	e underlying cause	given in Part I.	23b. DI	d tobacco use co	ontribute to	the cause of death
							1)	CYes 2□No	3 Prob	ably 4 Unknow
							24a. Wa	s an autopsy	ava	ilable prior to
-			and the same of th	_				101111001	con	nplation of causa leath?
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_	00.144	and the second second					7	<u> </u>		1 45
ė	25. Was case refa examiner?		Hospital:			26. Place of De				
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2	27. Manner of Dea Natural	th 5 ☐ Panding	28a. Date of Inju	ury 28b. Time	y V		28d. Describ	e how injury occur	rred	
	2 Accident	investigation			M 1	Yes 2 No				
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	ZOU. FIACE UI III	jury - At homa, farm, tc. (Specify)	straet, factory, offic	ce	281. Location City or T	(Street and Num. own, State)	ber or Rural	Route Number,
	4 🗔 () () ()		building, at	ic. (opecny)				,,		
1	29a. Certifier	Certifying Phy	valcian: To the best	of my knowledga, de	ath occurred at the	time, date and place	, and due to th	a causa(s) and m	anner as sta	ated.
	(Check only one)	2 Medical Exam	Iner: On the basis o and manner st	of axamination and/or	invastigation, In m	y opinion, death occu	irred at the time	e, data and placa,	and due to	the cause(s)
1	29b. Signature and	d title of certifier	7		29c. Lice	ansa number		29d. Data signe	ed (Month, E	Day, Year)
1	1	.)	an			12001		June !		
L		mas	7 100		r	1200		owne.) 17	110
3	30. Name and add	ress o person who	impleted cause of	daath (Item 23a) (Typ	oe, Print)					
	5	JAMES WY	WG 22	N. Greene	Street					
3	31. Date filed (Mor	nth, Day, Year)	32. Regist	rar's Signature						
		JUN 0 4 19	98 >4	whice Davidson	Rando 90					
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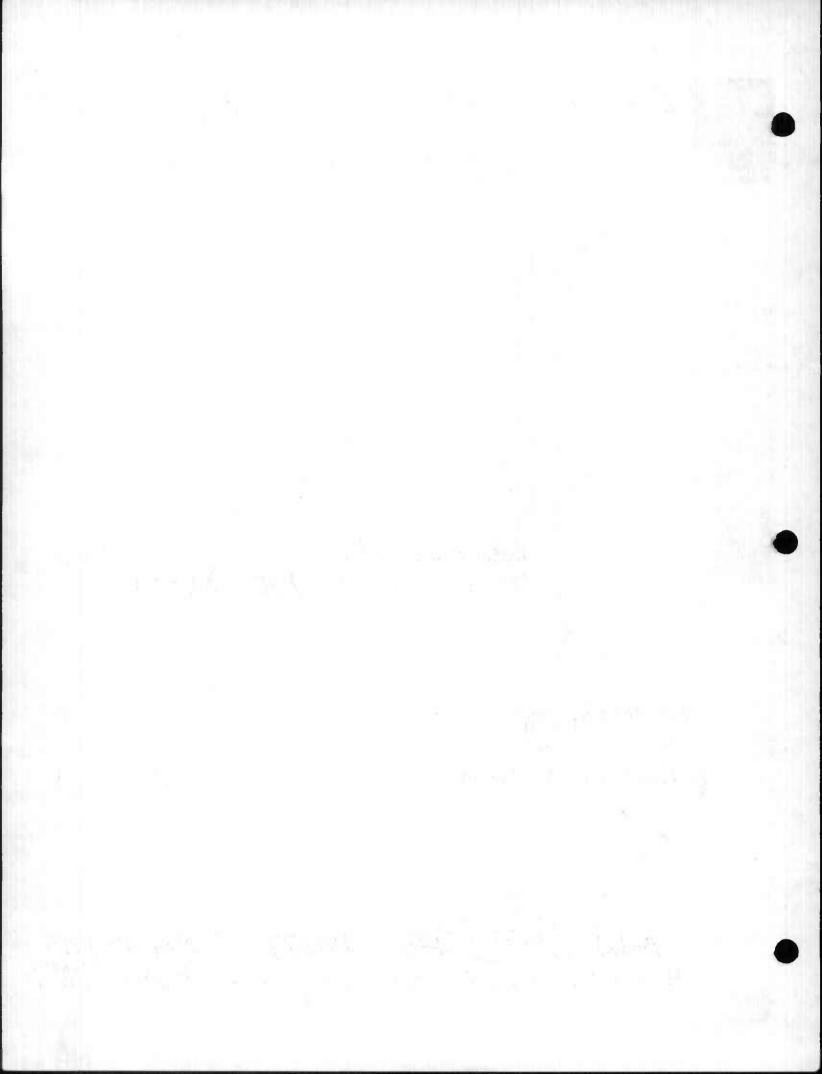


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	Physic /Medi		1. Decedent's Nan	x R	ay							2. Dete of I	1 3	ל ל	448	3. Time of Death
L	Examiı	ner	Howard	d Coun	ty Gene	ral			1 Van	Colu	mbia		Į.	County	ard	
a.	Funeral Director		5. Social Security in 220–72–29. Usual Rasidance of	908	6. Sex 1□M ½ ☐ F	7. Age (77 Yrs.	Months	Deys		Min.	8. Dete of B (Month, I Apri	Dey, Year)	1921	9. Birthpl Count Ba	ece (Stete or Foreign ry) ltimore
	Maryland In show	tor	10a. Stete Maryland	10b. County Howard	đ	1	Oc. City, Town or I Columbia	ocation							10	od. Inside City Limits
	h with the 23a or 28a at be not	Funeral Director	10e. Street end Nu 9341 Ou	mber urtime	Lane			10f. Zip	Code 210)45				izen of W JSA	/het Count	try?
020	within 72 hours aftar death with the Maryland ilena. Than "natural", or items 23a or 28s-f show the Medical Examiner must be notified at	by	1212	ried 2□ Marr	12. Wes Dec Armed F 1 Tes If Yes, G Yeer or I	Forces? 2XXXNo Bive	er In U,S. 13	Was Deced If Yes, spec				ecify Yes or I Rican, etc.)	No-		- America k, White, e	etc.
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lan)	and and and		19a. Informant's N	lame/Reletions	hip (Type, Print)	Unani	19b. Mai	ing Addrass	(Strae	t end Numb	er or Rur	ral Route Nun	n <i>ber, City</i> o	r Town,	Stete, Zip	Code)
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Baltimore	80=5			Cremation	3 Removal from	n State	cemetery, cr	emetory or o	ther ple	,	. To see	Dete			City or Tov	
Ē	E 65 - 2		4 Li Denation 21. Signature of F	5 Other (Spuneral Service)				2. Name en			ity				•	y, Maryland
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no		:lou:	27. Mannar of Dee	5 Pendin	9	of Injury onth, Doy Y	'ear) 28b. Time Injury	of 2	8c. Inju	ıryet ork?]Yes 2. □		28d. Describ	e how Injur	y occurre	ed	
Division	Attended dasti	Certification:	2 Accident 3 Sulcide 4 Homicide	Investig 6 Could r datarmi	not be 28a. Plac	e of Injury ding, etc. (- At home, farm, s Spacify)						(Street en own, Stete		or or Rurel	Route Number,
ioR	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical C	29e. Certifiar (Check only one)	10 Certifying	g Physicien: To the Examiner: On the b end mer	a best of r besis of ex	eminetion and/or i	th occurred anvastigation,	at tha ti in my	ima, data ar opinlon, dee	nd placa, eth occur	end due to th	e, date and	and mar plece, a	nner as ste	etad. tha causa(s)
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			30 Name and edd	ress of parson	who completed cau	MD	th (Itam 23a) (Type	Print) C	001	nty	Le	neral	Hos	pita	10	Olumbia 2104u
	Sta Registr	-	31. Date filed (Mor	oth, Dey, Year) 1 4 1998		Registrer's	Signeture	2								0

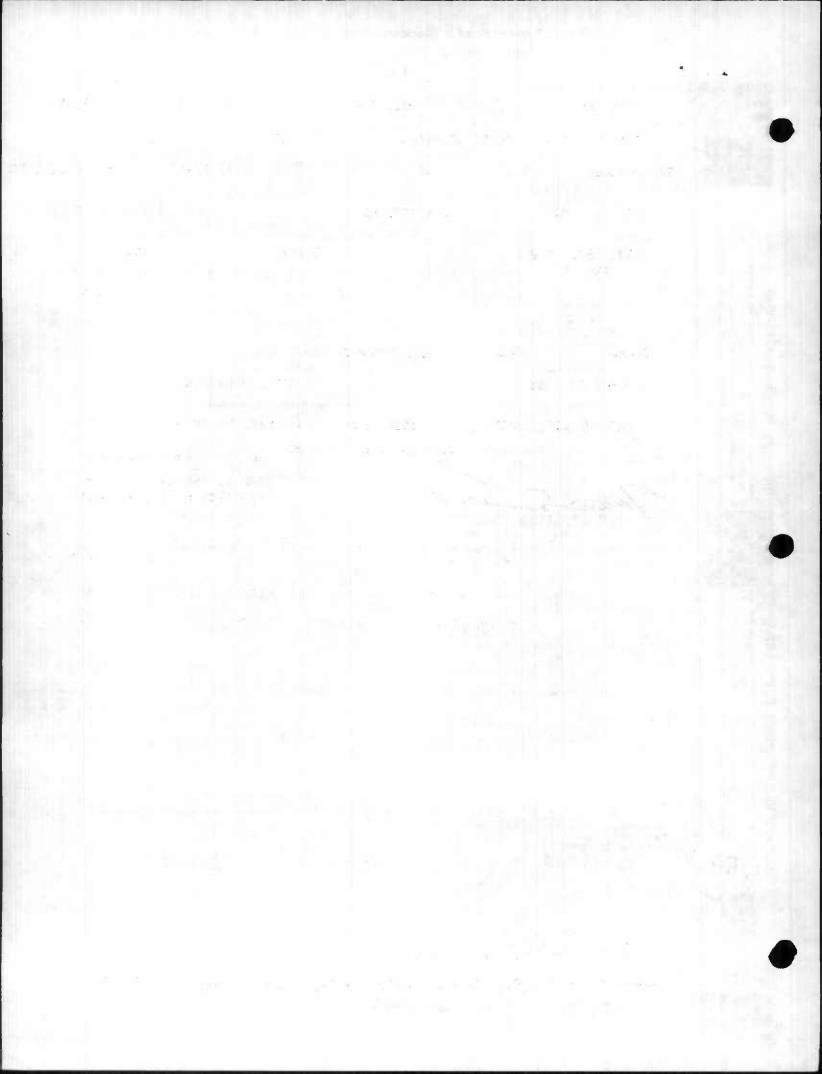


State of Maryland / Department of Health and Mental Hygiene 98 17210

	•			Cer	tificate d	of Death		Reg. No.		1940
61	1. Decedent's Name (First, A	fiddle, Last)					2. Data of Dea		Vear	. Tima of Death
Physician /Medical	FRANCINE			ROBII	NSON		5/29/	98	2	2:45PM
Examiner	4a Facility Name (If not instit					4b. City, Town, or l	ocation of Death		of Death	
<u> </u>		EORGES COI	_		Williador 4 Vic	CHEVERLY ear If Under 24 Hrs.	1	PG		
Funeral Director	5. Social Security Number 578–78–2029	6. Sex		s. lest birthday) 42 Yrs.	# Under 1 Ye Months Da		8. Date of Birt (Month Da.)	Year)	9. Birthplace WASHI	NGTON, I
and w	Usual Residence of Decedar 10a. Stata 10b. Co		10c. C	City, Town or Lo	cation				10d.	Insida City Limits
the Marylar 28a-1 show notified a	DC	PG	H	YATTSVI	LLE					Yes 2 No
or 28a-f	10e. Street and Number				10f. Zip Cod	ja		10g. Citizen of V	What Country?	
23a or	3402 55T					20784		US	SA	
urs after dea	3 ☐ Widowed 4 ☐ Divo	Married 1 Y	Decedent Ever in d Forces? les 25 No , Give A or Dates:			of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No Rican, etc.)	Blac	e - American I ck, White, etc. BLACK	
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e filed within the Hygiene. other than went, the M	12 YEARS 17. Father's Name (First, Mid		E	ACCOUN	T/NOTE	18. Mother's Nen	no (First Middle	Maidan Cumam	201	
Mental Mental srked o	aronar a						ROBINSO		10)	
2 she	19a. Informant's Name/Rela					reet and Number or Ru				
and fealth m 27	MAMIE Mc 20a. Method of Disposition	INTOSH (MO		6610 Place of Dispo		D ROAD/CAF	Date Date	IGHTS, 1		
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permit. Departr Importu any inj	21. Signature of Funeral Ser	vica Licansee	Sel	9 "	. Name and Ad	ddress of Facility JOF 303	N T. RH		o., INC OC 2001	
	23a. Paul. Enter the diseas	e, or complications the List only one cause	nat caused the de- on each line.	ath. Do not ente	er the mode of	dying, such as cardiac	or respiratory a	rrest,	Int	proximate erval Between
Physician /Medical	Immediate Cause (Finai	0			, ,					nsat and Death
Examiner	disease or condition resulting in death)	a. 5	EPTIC	2 Ha	2K				0	74 (463
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n and rai-transit	Convention that are distant	b	73160	(or as a conseq	ITIS,	SIAG	SIVI	ECUE) 0	1 1000
	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		PAALCI	KNOT	- 1 1 I	17 100	7			21495
physician a the buria	that initiated avents	C	Due to	(or as a conseq	uence of):	JE LIVIS	>			رداور
# p# %	resulting in death) Last	L.		·	•					
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s of the s	Part II. Other significant con	ditions contributing	to death but not re	sulting In the ur	nderlying cause	a givan in Part I.	23b. Did	tobacco use co	ntribute to the	e cause of death?
that the deby destay	ANEMIA						10	Y00 20 No	3 Probab	ly 4 Unknow
n signed uid be de ed by B							24a. Was	an autopsy		autopsy findings
been show								rmed?		ble prior to letion of causa
The lass page 2							40.	Yes 212 No		
	25. Was case referred to me	dical				26 Diago of Do	ath (Check only o			es 2 No
	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3□ DOA	Other:	ioma 5 ☐ Resid		er (Specify)	
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A 4 4 9	1 Natural 5 Pe	estigation	Month, Day Year)	Injury		1 Yes 2 No				
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	(Check only 2 Med					ne time, date and place my opinion, death occu				
To the Horning 24 h To the Fur complete	one)	and i	manner stated.							
5459	29b. Signatura and titla of ce	1				canse number		29d. Date signe	(INIONIN, DA)	, rear)
	Inda	NO	uenn	N	I	21428		611	198	
	30. Name and address of per	son who completed	cause of death (Ite	em 23a) (Type,	Print)					

State Registrar

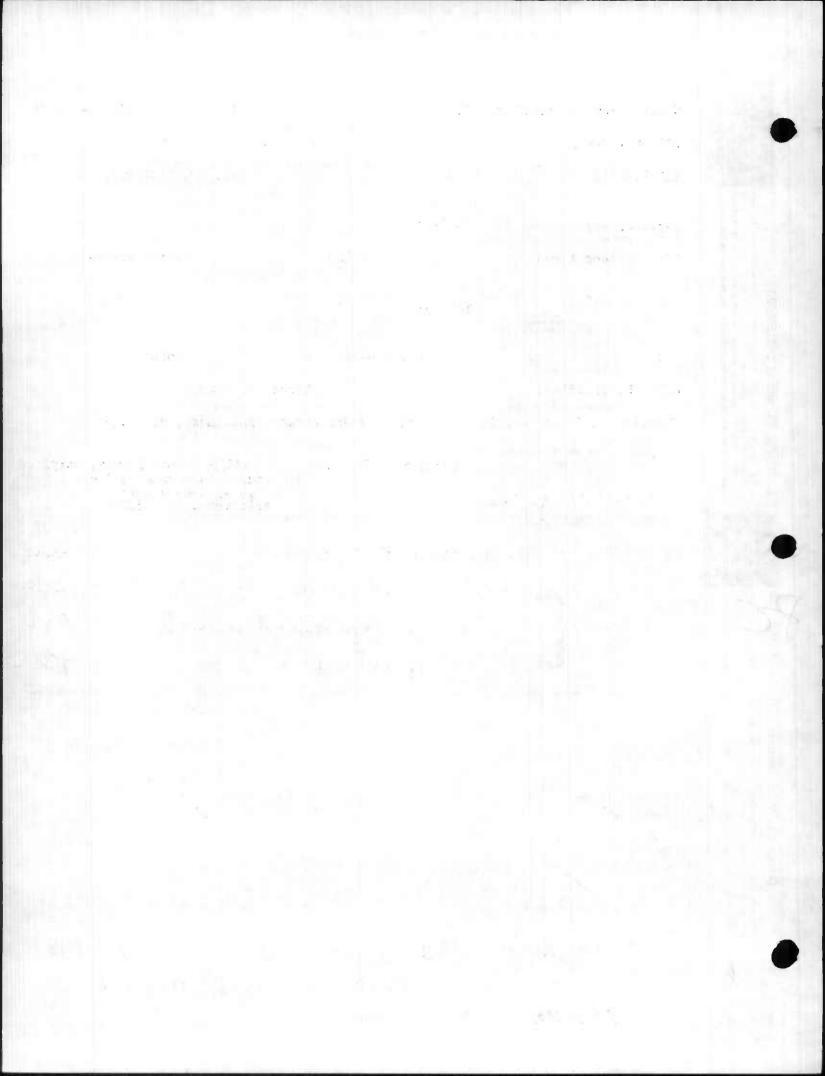
1299 LAMBERTON DRIVE, SILVER SPRING, MD., LINDA D. GREEN, MD.,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7 3 4 9 State of Maryland / Department of Health and Mental Hygiene

nysician		Decedent's Name PALMER	e (First, Middle, Las S.		NERSON				2. Date of Do Month	Reg. No.	Yeer	3. Time of D
Medical	ŀ		f not institution, give					4b. City, Town, or	JUNE	2, 19	4.00	1:00]
xaminer			NTAGE POINI					COLLIMBI			WARD	
nerai ector		5. Social Security N 501-03 Usual Residence of	umber 6. Se			81 Yrs.	If Under 1 Yes	or If Under 24 Hrs	8. Dete of Bi	rth ay, Year)	9. Birthpl Count	lace (State or F try) H_DAKOTA
notified at		10a. State MD	10b. County HOWAR	D	10c. Ci	ty, Town or Lo	coation COLUMB	Ι Α			10	0d. Inside City
Direc	3	10e. Street and Nur	mber				10f. Zip Code			10g. Citizen of V	Whet Count	try?
Tal Cal	2	5400 VA	NTAGE POINI	ROAD APT	. #706		2:	1044		U.	.S.A.	
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any injury or other traumatic event, the Medical Exa once. To Be Completed by	nipleted	(Spec	15. Decedent's Ed ify only highest grad ndary (0-12)	ucation	or 5+)	(Give life.	DO NOT use reti	e during most of wo	rking	16b. Kind of Bu		
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any injur			neral Service Licens		1	22	2. Name end Add	ress of Facility WI	TZKE FUNE	RAL HOMES,	INC.	(ILAND
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** 4:09 AM Charles Edward Shifflett, Sr. 1998 May 31 /Medical 4b. City, Town, or Location of Deeth 4a Facility Nema (If not institution, give street end number) 4c. County of Death Examiner 1211 Glyndon Avenue Baltimore n/a If Under 1 Yaar | If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth **Funeral** 1 M 2□ F Hours Yrs. Director 215-26-6515 66 Feb. 10, 1932 Virginia Usual Rasidance of Decedant with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inaida City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 √ Yas 2 No Directo Baltimore Maryland n/a 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1211 Glyndon Avenue 21223 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglena. Important: if item 27 is marked other than "naturaf", or items 23, any Injury or other traumatic evant, the Mendie Examment must Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 11 Marital Status 1 ☐ Yes 2 □ No If Yes, Giva Year or Datas: 1948-51 1 Navar Married 2 Married 1□ Yas 2√2 No Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) bar tender hote1 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Ellis H. Shifflett Esther V. Howsare 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Charline Shifflett - wife 1211 Glyndon Avenue, Baltimore, MD 21223 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 → Buriel 2 □ Cremetion 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) 6/2/98 Glen Burnie, Maryland Cedar Hill Cemetery 21. Signatura of Funaral Sarvice Licensae 22. Name end Addrass of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. Wist only one cause on each line. Approximate Interval Between Onsat end Death **Physiclan** /Medical Immediata Causa (Final disease or condition rasulting in daath) Examiner Physician/Medical Examiner Sequantielly list conditions, if any, leading to immadiata ceusa. Enter Undarlying Cause (Disaase or injury that initiated avants nt Drabetes De Division of Vital Records, P.O. Box 68769 physici Due to (or as e consequanca of The law requires that the death certificate rasulting In death) Last 99 USB ed by the detached 23b. Did tobagco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1D fee 2□ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? page 2 s 1 Yes 2 DAK 1 ☐ Yes 2 ☐ No this certificate Physician: 25. Was cesa refarrad to medicel axaminar? Be 26. Piaca of Deeth (Check only ope) Othar: 4 Nursing Homa 5 Besidance 9 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Othar (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of Certification: 28c. Injury at Work? After t or Attending 5 Panding invastigation 1 TYas 2 No death. I Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Specify) 4 Homicida efter 24 hours 29a. Certifier 1 Cartifying Physician: To the bast of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. Medical completaly 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) within 2 29b. Signature end title of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Nama and addrass of parson who complated causa of death (Item 23a) (Type, Print) BALTIMORE FERRY ROAD HOLLINS 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura relia Savidson JUN 0 4 1998 Registra



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie ? Certificate of Death Amend: #7 Per FH Film G760 6-4-98RC 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month **Physician** 98 4a Facility Nama (If not institution, giva street and number) Mosella 6 01 2.2014 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner | H Under 24 Hrs. | 8. Dafa of Birth (Month, Day, Year) | 9 - 10 - 49 5. Social Security Number 6. Sex Britismore Cate of Foreign (State of Foreign Country) If Under 1 Year 7. Aga (In yrs. last birthday) **Funeral** 10 M 20 F Months Days 219 - 25 - 1194 Usual Residence of Decedent Yrs. 48 Director J. AMICA with the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f show the Medical Exampler must be notified at 1 Yas 2 No NIA BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3805 TERNDALE Funeral VENUE death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marifal Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Heelib and Mentel Hygiens. Important: if item 27 is merked other than "natural; or ite any findury or other traumatic event, I'm Medical Examination in Influry or other traumatic event, I'm Medical Examination 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEAMTRESS DRY CLEANING NIA 12 TH GRADE 18. Mother's Name (First, Middla, Maidan Surnama) 17. Father's Name (First, Middla, Last) ADELLA BAINES ADLPHUS / JERRELONG 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) TLE PADONIA SON KD. APT. 101, BALTO. MD. 21093 HOWELL LEWIN 20b. Place of Disposition (Nama of , cematary, cramatory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata KING MEMORIAL 6-6-98 KANDALLSTOWN. PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea 22. Name and Address of Facility any in VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO . NATL PIKE, BALTO. 23a. Part1. Enter the discusse, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart unifure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disaese or condition resulting In death) **/Medical** Betlovilus Examiner Due to (or es e consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Dua to (or as a consequance of): SB USB lew requires that the death 23b. Did tobacco usa contribute to the causa of death? P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. the 3 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was en autopsy performed? Completed peen has page 2 The certificate 1 Yes 2 NO or Attending Physician: 25. Was cese referred to medicel examiner? Be 26. Place of Death (Chack only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Po 1 Inpatient 2 ER/Outpatient 3 DOA this funerai 28e. Date of Injury (Month, Day Yaer) 27. Manger of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: After 5 Pending Investigation 1 Natural the Funeral Director: After and the funeral Director of the funeral Director of the funeral filled in by the funeral funeral filled in by the funeral funeral funeral funeral functions of the function of the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, tarm, straet, factory, office building, etc. (Spacify) 4 T Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler edical completely (Check only one) within 2 \$

State Registrar

JUN Q 4 1998

29b. Signature and title of certifier

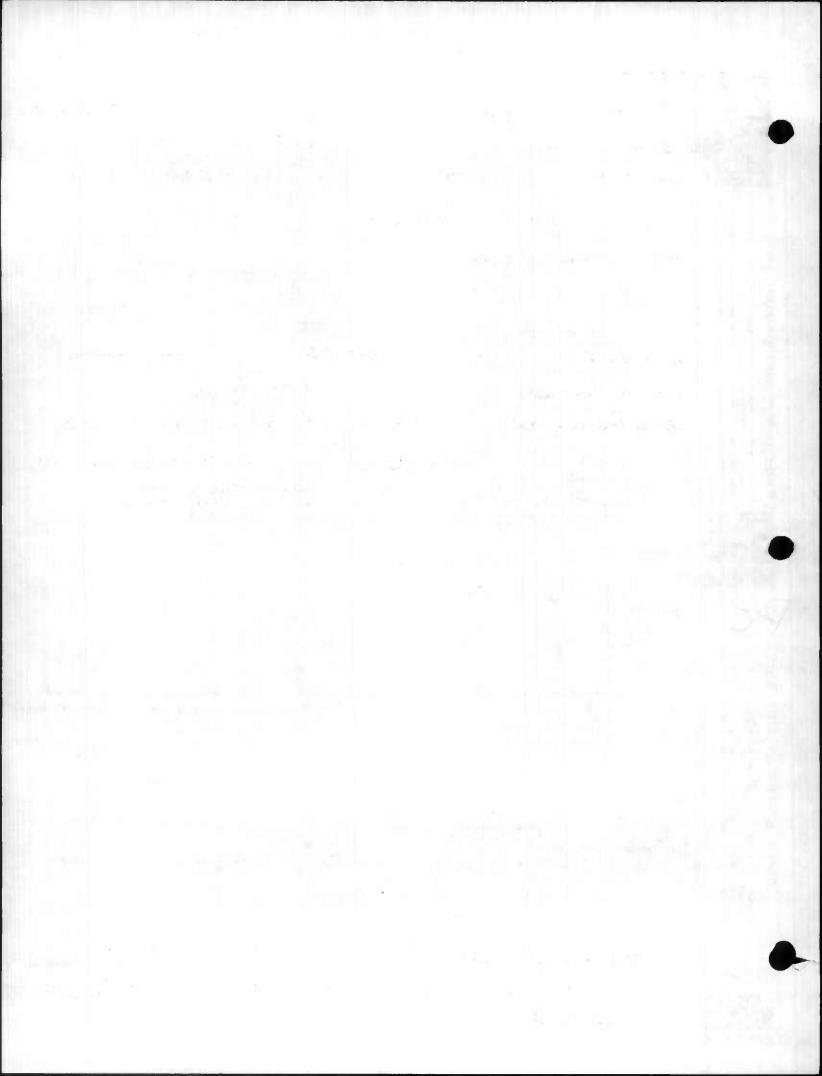
31. Dete filed (Month, Dey, Yeer) 32.

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Beluelose Guite 302 Butimorphozors W 2411 32. Registrar's Signature

29c. Licansa number

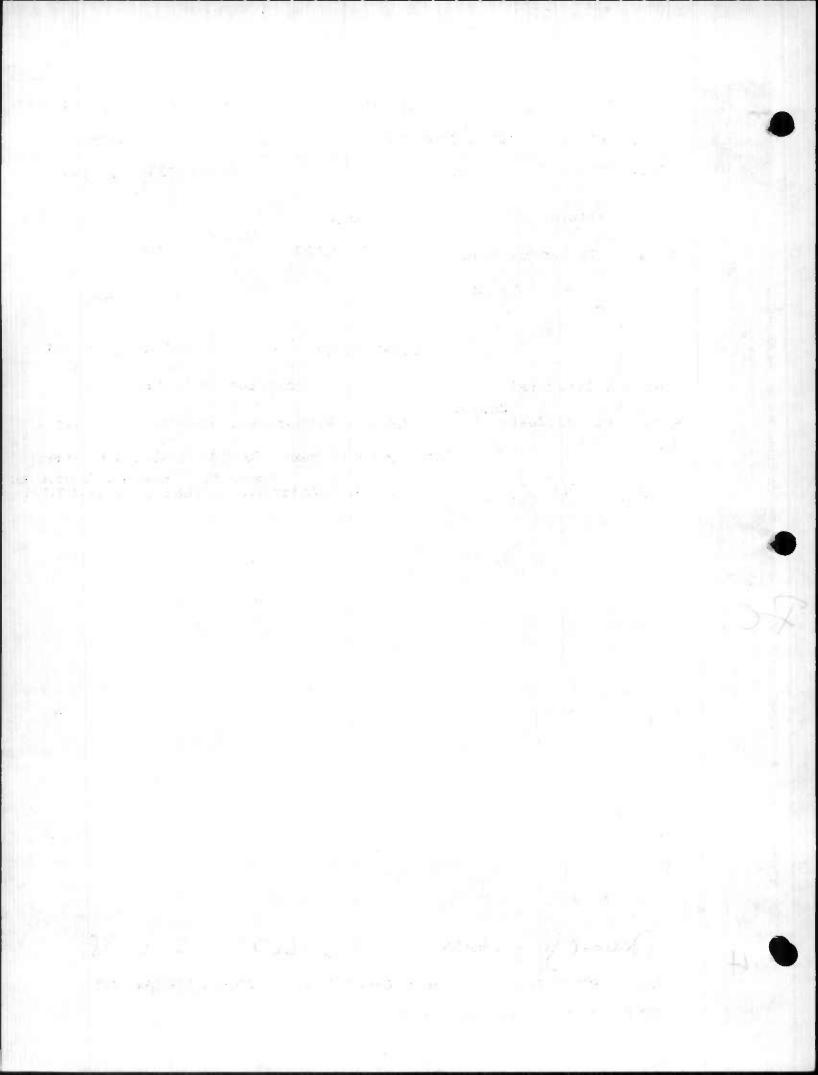
29d. Dafa signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month MAY **Physician** 30, 1998 MARTO TIRABASSI 7:14 PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RIVERVIEW NURSING CENTRE INCORPORATED BALTIMORE BALTIMORE If Under 1 Year Months Deys If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. lest birthdey) 8. Date of Birth Birthplece (State or Foreign Country) Funeral Months Hours 1**X** M 2□ F 216-20-3268 10/14/1926 71 **Director** Maryland Usual Residence of Decedent the Meryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Peges 1 and 2 should be filed within 72 hours after death with the Merylar nent of Health and Mental Hygiene.
ant: If item 27 Ia marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Madrial Examines invart to notified as Md. Baltimore 1 ☐ Yes 2X No Director Dunda1k 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21222 USA 1877 Church Road 1 1 655 Funeral 12. Wes Decedent Ever in U,S. Armad Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indien, Bleck, White, etc. 1 X Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: White by Specify: 3 Widowed 4 Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Steel Worker Bethlehem Steel 8th 17. Fether's Nema (First, Middle, Lest) 18. Mother's Neme (First, Middle, Malden Surneme) Domenica Vincenzo Tirabassi DeSantis 19e. Informent's Neme/Reletionship (Type, Print) Daughter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Maria Lisa Hardesty 1205 Oak Harbor Ct., Pasadena, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Buriel 2 ☐ Cremetion 3 ☐ Ramoval from State Sacred Heart of Jesus 6/3/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansas 22. Name and Address of Feellity Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St., Baltimore, Maryland 21224 aria annero 23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdlec or respiretory errest, shock, or heart feilura. List only one cause on each line. Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) eneutia YM Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760 Physician/Medical The law requires thet the death certificets the Due to (or as a consequence of): 98 Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Hyperteusion been signed by should be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings avelleble prior to Completed 24e. Wes en autopsy performed? complation of cause of death? page 2 1 ☐ Yes 2 Dolo certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Diractor: After this certifica director, Be 25. Wes cesa referred to medice! 26. Plece of Deeth (Check only one) Other: 4 Sursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident the 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) in by 4 Homicide 29e. Certifier 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner as steted.
25 Medicat Exeminer: On the besis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) and menner stated. Medical completely (Check only one) the within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 'Usel amound 30. Name end eddress of person with completed ceuse of deeth (Item 23e) (Type, Print) MICHAEL SCHWARTZ, M.D. 5517-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND 21225 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State hie Friedson-Randelle JUN 0 4 1998 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Lest) 2. Date of Deeth **Physician** Month Mark Alphonso White June 1998 1:45 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital City Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 XM 2 ☐ F Yrs Director 20 1998 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner main be notified at 10d. Inside City Limits 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? a1a15 permit. Pages 1 and 2 should be filed within 72 hours effer death 1 Department of Health and Mental Hydrens. Important: If fiem 27 is marked other than "netural", or Items 23s any Injury or other traumetic augus. 2526 ome Race - American Indian, Black, White, etc. Was Decedent Ever in U,S Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2 No à 3 ☐ Wildowed 4 ☐ Divorced 100 Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) drian 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Date 20c. Location · City of Town, State 2526 drian decome 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Baltimore, mo 104 4 □ Donation 5 □ Other (Specify) letro -vernatory 22. Name and Address 21. Signeture of Funeral Services Formeral Home P.A. Jary 270 Frolliton Rus Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final 20 min. Fetal Immaturity disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initioted events resulting in death) Lest Due to (or es a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed peen has page 2 certificate 2 🛛 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 1 Natural 5 Pending Injury Investigation 1 Yes N/A N/A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide N/A

68760 Box Division of Vital Records, P.O.

 Mospital or Attending Physician:
 24 hours effer death.
 Funeral Director: Affer this certifica Within 2.

State

edical

29a. Certifier

(Check only one)

29b. Signature and title of pertifier

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

relia Davidson

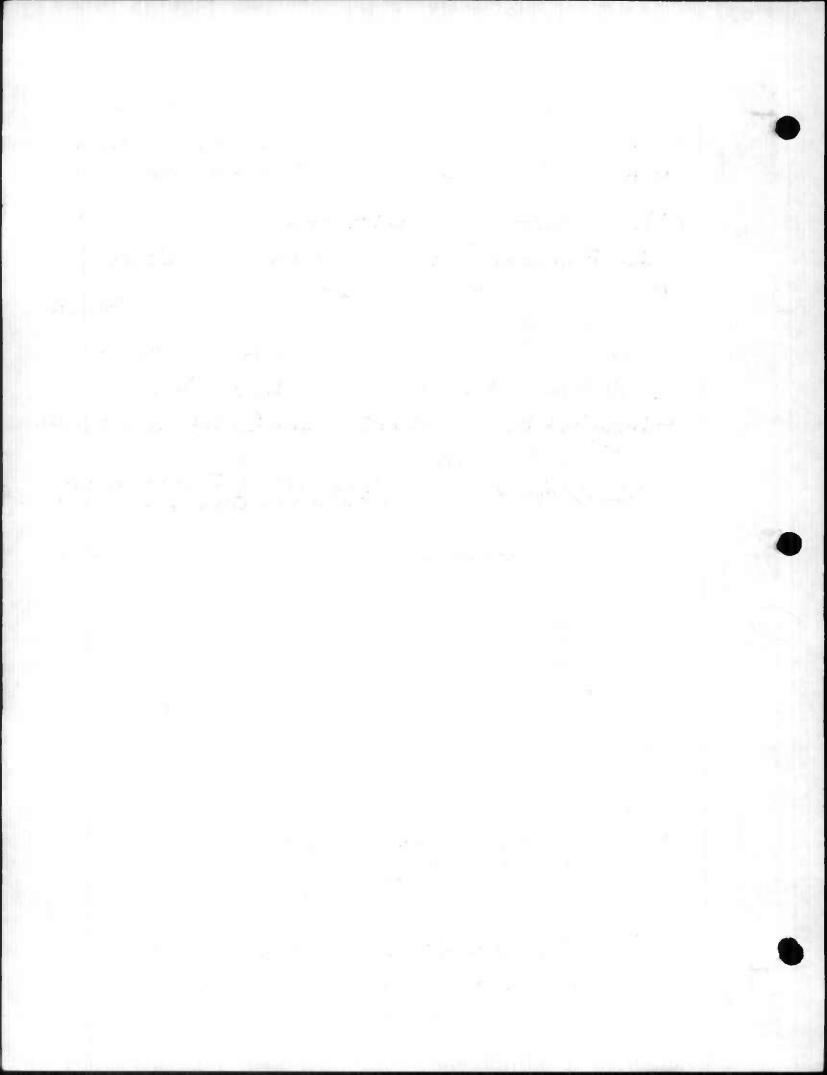
1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29c. License number

29d. Dete signed (Month, Dey, Year)

Sally S. Sondergaard 2401 W. Belvedere Ave. Balto., MD 31. Date filed (Month, Day, Year) JUN 0 4 1998 32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1:15AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAINT 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 1 M 2 F 213-62-3607 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 7 is marked other than "natural", or items 23a or 28a-f show treumetic event, the Medical Examinar must be notified at 1 Tes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 14. Race - American indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Pages 1 and 2 should be filed within 72 hours after in ent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite Yes 2 7 Mo Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Delvorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Su Be 19e Informent's Name/Relationship (Type, Print) Important: If Item 27 is n any injury or net 20b. Plece of Dispos 1 Burial 2 □ Cremetion 3 □ Remove from State 4 ☐ Donetion / ☐ Other (Specify) 21. Signeture of Emerel Servica Licenses 23a. Part f. Enter the orlease or complications that caused the deeth. Do not enter the shock or board failure. Use only one cause on each line. Approximete Intervel Between Onset end Death **Physician** halopathy immediate Ceuse (Finel disease or condition resulting in deeth) /Medicai Examiner men Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? TENSION 1 ☐ Yes 2 No 3 Probably 4 Unknown þ BIPOLAR DISORDER 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed SCHIZOPHRENIA 1 Yes 25. Wes case referred to medical exeminer? 86 28. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 EP/Outpetient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To To the Mospital or Attending Ph - within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Desth 1 Neturel 2 Accident 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

State

29a. Certifier

29b. Signeture end title of certifier

Baltimore, Maryland 21215-0020

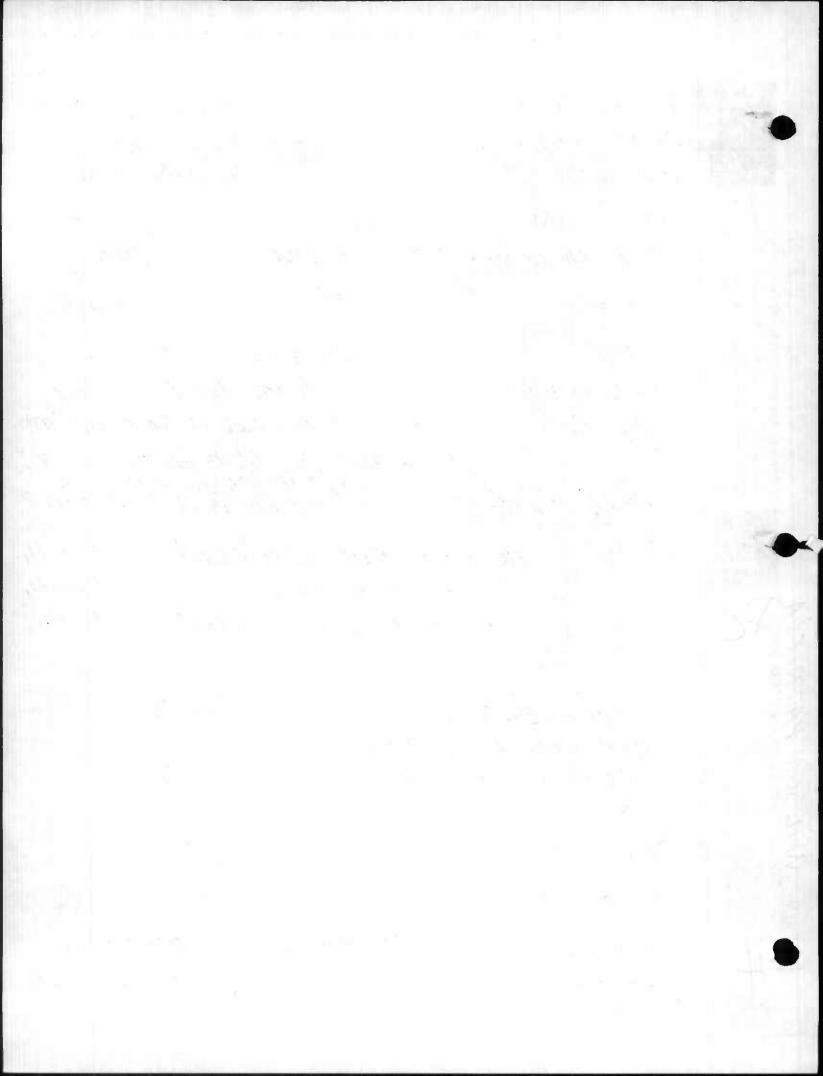
person who completed ceuse of deeth (Item 23e) (Type, Print) Gaton Ave, Balto, MD 21229

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(a) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 2 Dey Month 1998 Wyatt Robert S. June 8:40 pm 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death 237 List Ave. Pasadena Anne Arundel Hours Min. 8. Date of Birth (Month, Day, Year) NOV . 26, 1922 6. Sex 1 M 2 ☐ F If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthpiece (Stete or Foreign Country) Deys Months 577-24-4365 75 Yrs Missouri Usuel Residence of Decedent 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 237 List Ave. 21122 USA 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 1943 If Yes, Give Year or Dates: 1945 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced White 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Coilaga (1-4or 5+) 12 Transportation Manager Space Flight Center 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumeme) Leonard Searcy Wyatt Ola Pearl Koehler 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Susan Wyatt - Daughter 275 10th Street, Pasadena, MD 21122 20e. Method of Disposition 1 Buriat 2 Cremetion 3 Removel from Stete 20b. Place of Disposition (Neme of cematary, crematory or other place) 20c. Location - City or Town, Stete Dete St. James Episcopal Cem. 6/5/98 Lothian, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme and Address of Fecility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23e. Pert1. Enter the disease or complications that caused the deth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel disease or condition rasulting in deeth) PNEUMONIA 10 days Due to (or as a consequence of) Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 → Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellebie prior to completion of ceuse of daeth? 24e. Wes en eutopsy performed? PERIPHERAL VASCULAR DISEASE EMPHYJEMA 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

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page 2 certificate has

this funeral

After

he Hospital or Attending PI in 24 hours after death. he Funeral Director: After the pletchy filled in by the funera

To the Hospital o within 24 hours af To the Funeral DI completely filled in

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Completed

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Certification: To

Records,

of Vital

Division

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

2 should be filled within 72 hours after death vand Mental Hygiene. Is marked other than "naturs!", or items 23

permit. Pages 1 and 2 should be file. Department of Health and Mental Hy, Important: If Nem 27 Is marked other any Injury or other traumatic.....

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Diseesa or injury that initieted events resulting in daath) Last

COLEBROVASCUCAR ACCIDENT

25. Wes cese referred to medicel exeminer? 1 Yes 2 No 27. Menner of Deeth

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Hasidance 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 No 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only

2 Accident

3 ☐ Suicide

4 - Homicide

31. Dete tiled (Month

1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, date and plece, and due to tha ceusa(s) end menner es stated. 2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, data and place, and due to the causa(s) and menner stated.

29b. Signature and title of certifier

JN 04 1998

5 Pending Investigation

6 Could not be datermined

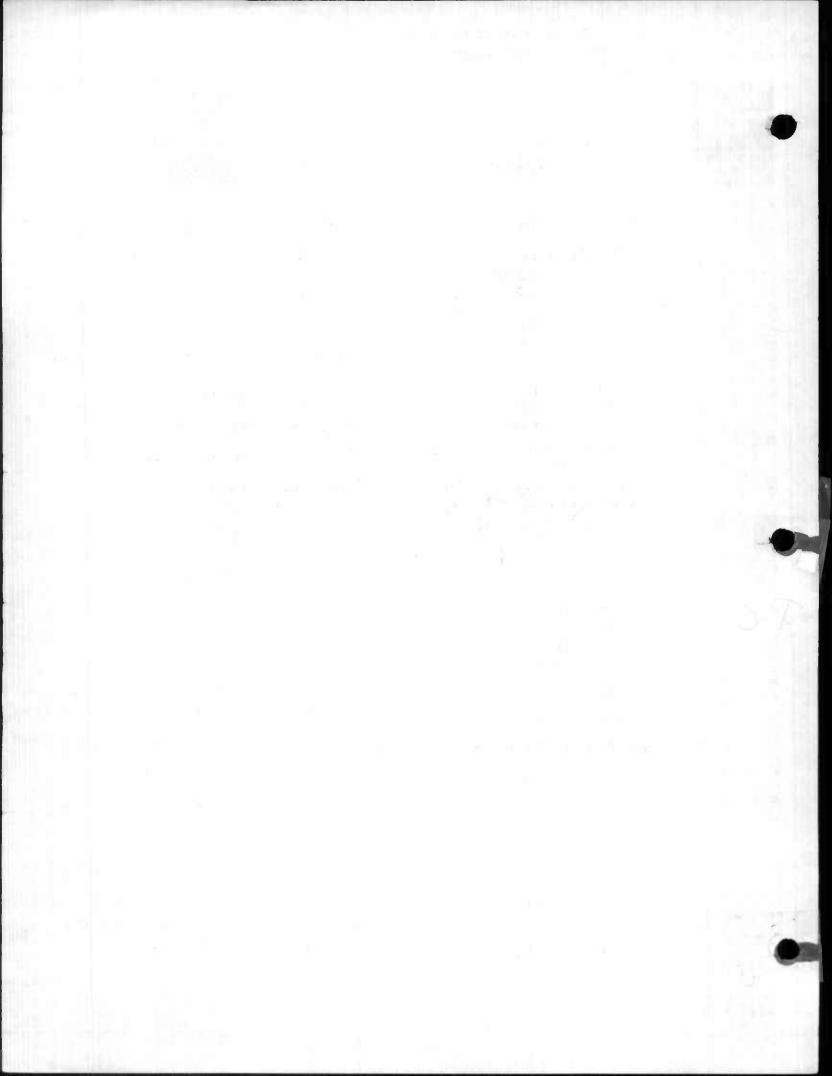
29c. License number 21776

30. Neme end eddress of person who complated cause of death (Item 23a) (Type, Print) NUNDRAMO 3001

HANDVER CT BARIMORDERLES

Registrar

32. Registrar's Signature Fulia Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth JUNE NORMAN WINKLER SR 2:200M 4a. Facility Name (If not institution, give street and pumber) 4b. City, Town, or Location of Death HOWARD County General COLUMBIA 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth Month, Day, Year) August 5,1925 9. Birthplace (State or Foreign Days 150 M 2□ F Missouri 489-28-6042 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Howard County Columbia: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10174 Pasture Gate Lane 21044 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 X No Specify: Specify: white Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Elementary/Secondery (0-12) College (1-4or 5+) personnel specialist US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Arthur Winkler Anna Weber 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Nancy Winkler/daughter 402 Anthwyn Road, Narbeth, PA 19072 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 3JUN98 Baltimore, MD 4 □ Donetion 5 □ Other (Specify) 21 Senature of Funeral Pervice Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset and Death tmmediete Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? HTN, CAD, CVA, gout, SIP Abdominal 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

and Box 68760. physician Be Completed by Physician/Medical the Records, P.O. Division of Vital Certification: To

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

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Нете 23а

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or Headen you other traumatic contractions.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

by

traumatic event, the Medical Examiner naut be notified at

Acrtic Aneurysm repair, Hydrocephalis

1 Yes 25 No

Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be determined

29c. License number 00051958 29d. Date signed (Month, Day, Year)

cause of deeth (Item 23e) (Type, Print)

TWO KNOWN DAVE, COLUMBIA MD 24045 BOURSIOUNDH, MD 31. Date filed (Month, Dey, Year)

State Registrar

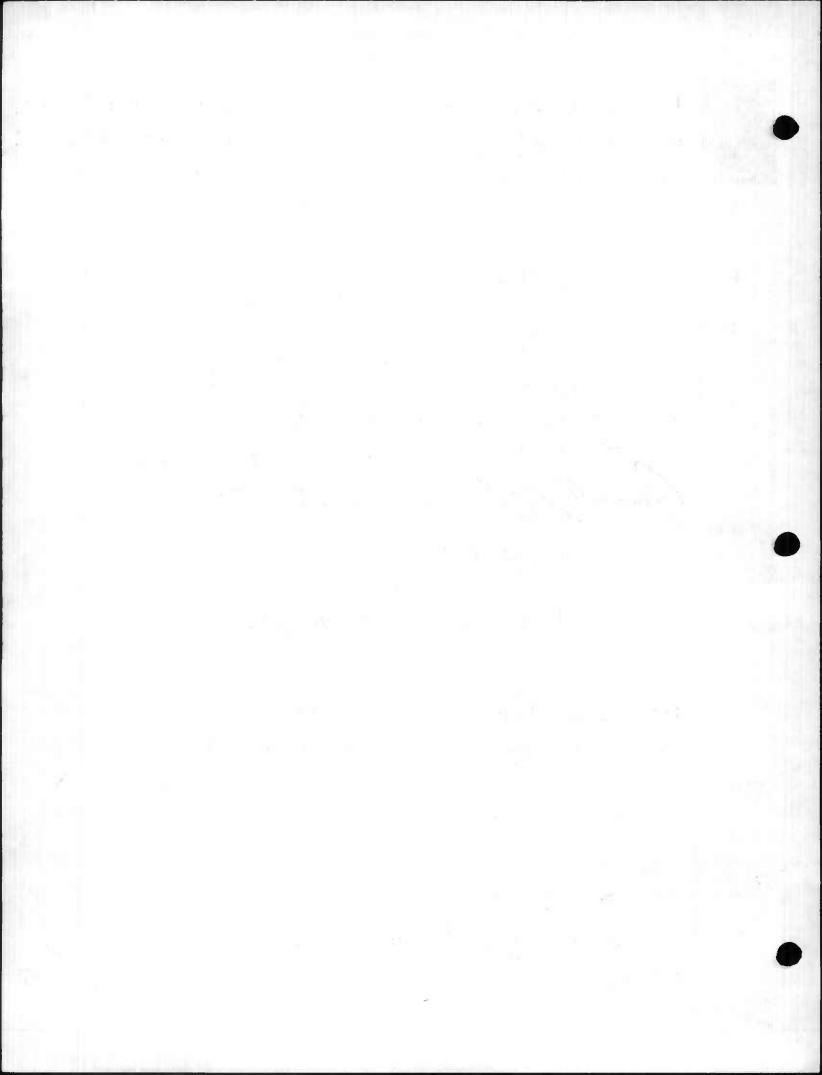
Medical

JUN 0 4 1998

32 Registrer's Signeture wa Davidson-Randale

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the within 2



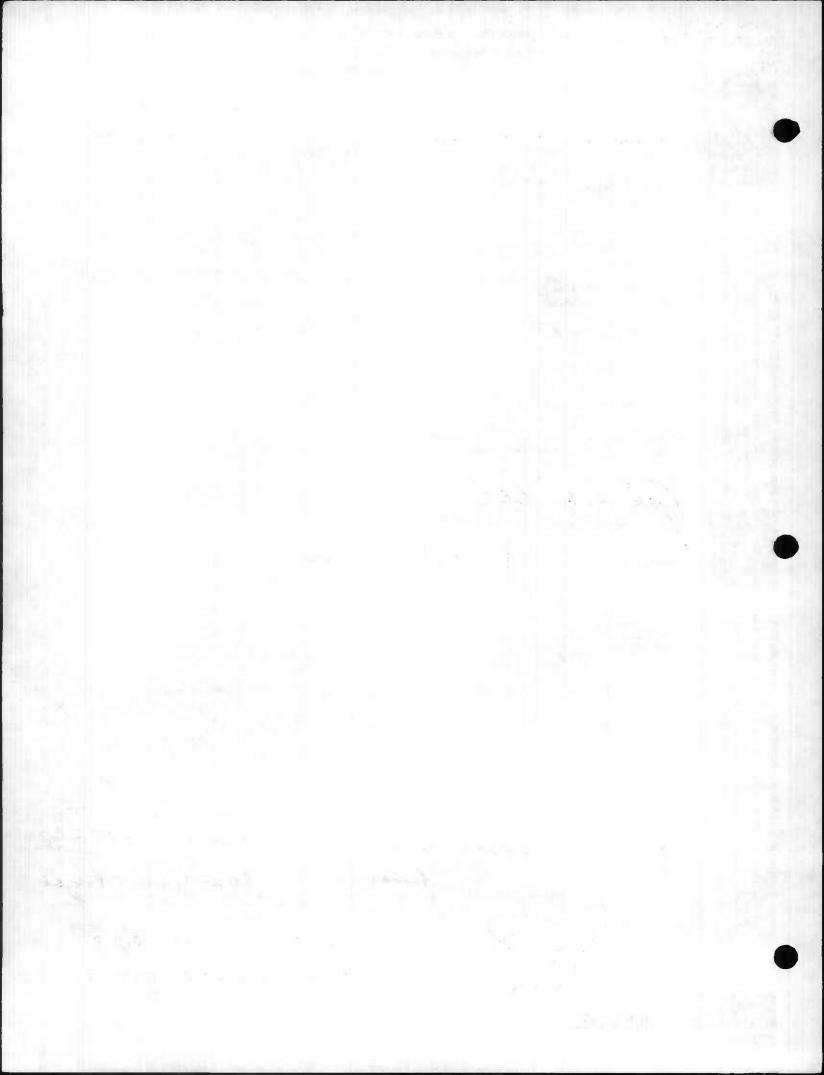
Registrar

31. Date filed (Month, Dey, Year State

JUN 0 4 1998

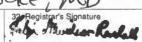
Registrer's Signature ul Davidson-Randall

DHMH 16 Rev 6/95



98-2965-031 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene STEPHANIE Certificate of Death BERMUDES Item: #5 Per Informant Film G760 6-5-98RC Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** STEPHANIE BERMUDEZ MAY 24, 1998 4:08P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number **Funeral** Months Days 1□M 2X F Yrs. 4 SEPT. 16, 1993 MARYLAND 579-23-8907 **Director** Usual Residenca of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow the Maryla 1 ☐ Yes 2 No Directo MARYLAND PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ra 23a or 8003 14TH AVENUE, 20783 APT. #102 UNITED STATES death Funeral 14. Race - American Indian, Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic avent, the Medical Example in 12. Was Decedent Ever in U.S. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 XYes 2 No Specify: by 3 Widowed 4 Divorced EL SALVADORAN WHITE "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18 Mother's Name (First Middle Meiden Sumame) 17. Father's Neme (First, Middle, Last) Health and Rental Health and Mental Health and Mental Health 27 is marked oth Be NATIVIDAD J. GONZALEZ BEATRICZ BERMUDEZ 2 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Pagas 1 and 2.
The stand of Health a ref. if them 27 is y or other terms. NATIVIDAD J. GONZALEZ, FATHER 8003 14TH AVENUE, APRT. #102, HYATTSVILLE, MD 20783 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 5/28/98 FORT LINCOLN CEMETERY BRENTWOOD, MARYLAND 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 art1. Enter the disease or complications that caused the dishock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Do not enter the mode of dying, such es cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Fine disease or condition resulting in deeth) Examiner Examiner certificata be axecuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of): 88 USB signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed paga 2 has Nes 2□ No cartificata Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 TER/Outpatient 3 DOA this Date of Injury 28d. Describe how Injury occurred funaral 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After Attending 9 1 Natural 5 Pending edesmon daath. 98 1 | Yes investigation 2 Accident after death Director: or or Rurel Route Number, 6 Could not be determined 3 Suicide Placa of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) end menner as statisting 40 NSULLE 29a. Certifi edical 2 Amedical Examiner: On the besis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. To the To the Comple and title of certifier 29d, Dete signed (Month, Dev. Year) 296. Sigratur 29c. License number

31. Date filed (Month, Dey, Year)



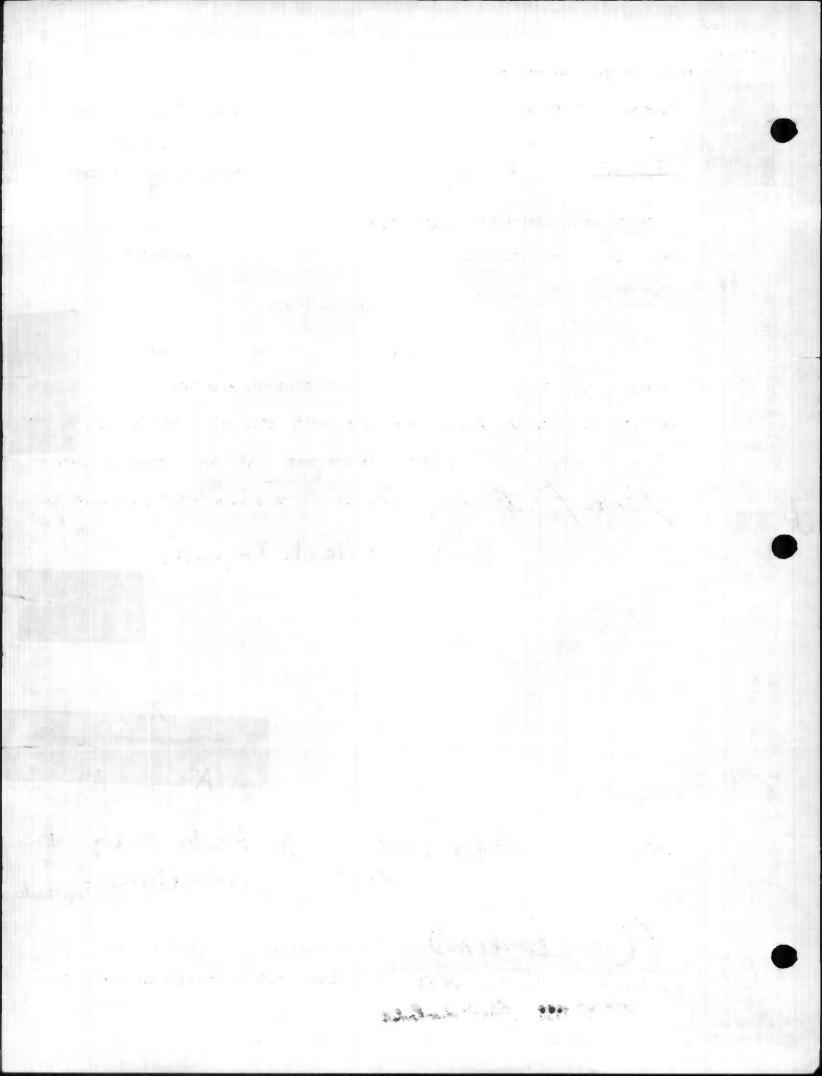
who completed cause of death (Item 23e) (Type, Print)

O.C.M.E.

MAY 25, 1998

111 Penn Street, Baltimore, Maryland 21201

State Registrar



State of Maryland / Department of Health and Mental Hygiene

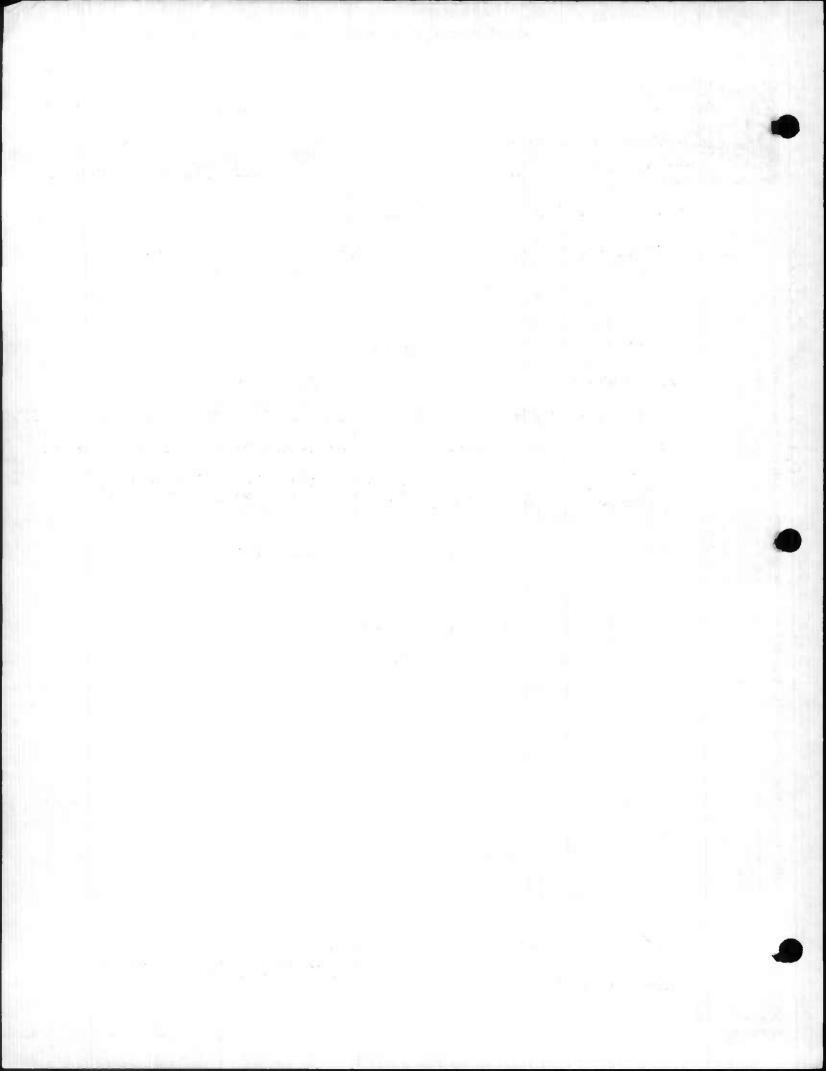
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth May 22, Physician 1998 Catherine A. Cole 5:49 am /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Civista Medical Center La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Dele of Birth (Month), Day, Year)

July 31, 1924 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 257F 579-20-4946 73 Yrs. WashingtonDC Director Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumstic event, the Medical Examiner must be notified as MD. St. Mary's Mechanicsville Director 1 Yes 2 No the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 29795 Claire Circle Catherine A, Cole Baltimore, Maryland 21215-0020 20659 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, While, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withIn 7 Hygiene. permit. Pages 1 and 2 should be filed withir Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumstic event. The Mental Injury or other traumstic event. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John Bushong Willie Bushong 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Herbert Cole, Jr. / Husband 29795 Claire Circle Mechanicsville, MD. 20b. Plece of Disposition (Neme of Dete 20c. Location - City or Town, Stete 20e. Method of Disposition MaryTand Veterans Cem. 5-28-98 Cheltenham, MD. 1 XBurlal 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture Funerel Service Licenses Arenart-Echols Funeral Home P.A. 23e. Pert1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. P.O. Box 567 La Plata, MD. 20646 Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) ranchasul monary Examiner Due to (or es a consequence of)! Examiner **buriel-transit** end Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. physician Tension Physician/Medical the to (or es e consequence of): ettending ŏ Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2 No ò 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peeu hes page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner/ 1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital P in by the funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Netural 5 Pending Investigation 1 ☐ Yes 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-23657 May 22, 1998 Capital EmCare, 575 Main Street #355 Laurel, Maryland 20707 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Capital EmCare, Edward Geneva, MD 32. Registrer's Signature 31. Date filed (Month, Dey, Year) State 1998 MAY 26 Registrar

DHMH 16 Rev 6/95

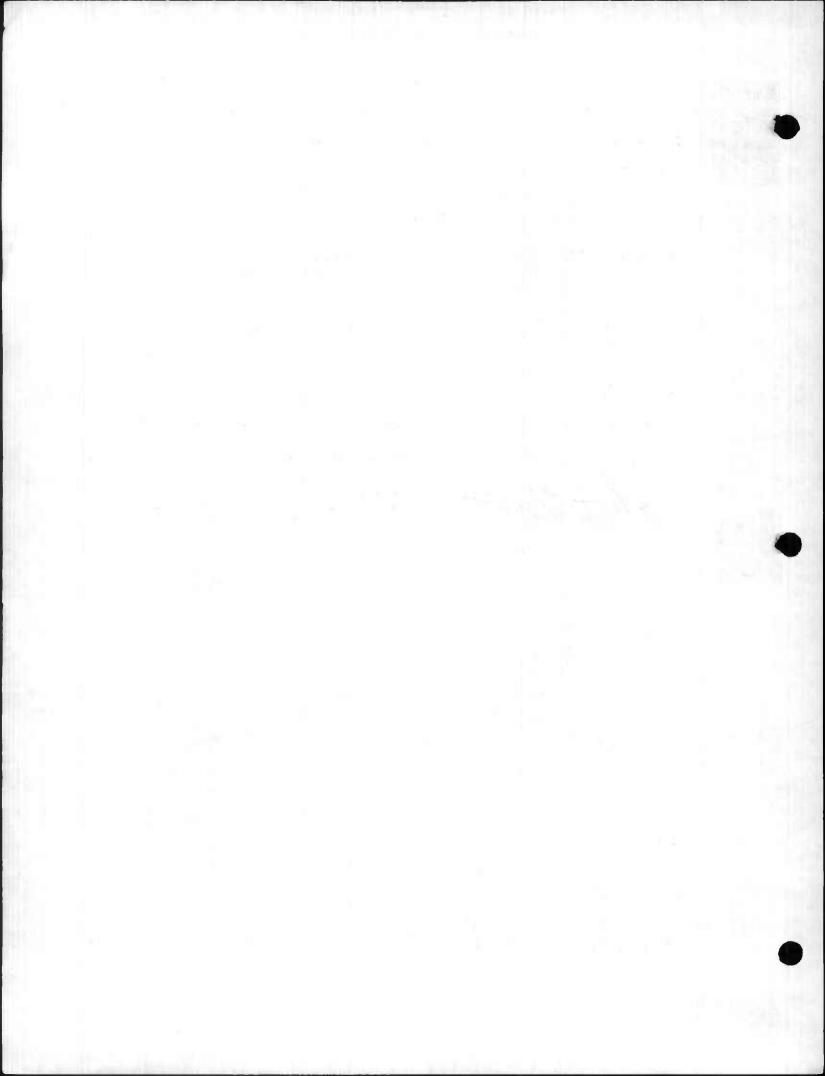


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Name (First, Middla, Last) 2. Data of Daajh 3 Time of Death **Physician** Month Edith Ruth May 24, 1998 Cooper 10:20 AM /Medical 4a. Fecility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CALVERT The Hermitage at St John's Creek Solomons If Undar 24 Hrs. 5. Social Sacurity Number If Under 1 Year 7. Aga (In yrs. last birthday) 8. Dela of Birth (Month, Day, Year) NOV 4 1903 Birthplace (Stata or Foreign
Country) **Funeral** 1□ M 2XF Months Days Hours 94 131-24-7885 **Yrs** Director Maryland Usual Rasidanca of Decedani the Manyland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or itema 23a or 28a-f show edical Examiner must be notified at Maryland Calvert Solomons . 1 Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? WITH PO Box 1509 13325 Dowell Rd 20688 USA Funerai death v 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indian, Bieck, White, atc. 11. Maritel Status Peges 1 and 2 should be filed within 72 hours efter reet of Health and Mental Hygiene.
Int: If tem 27 is marked other than "natural", or ite
Inty or other traumatic event, The Medical Estaturary or other traumatic event, The Medical Estaturary. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Detas: Baltimore, Maryland 21215-0020 1 □ Yas 2 No þ Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elementery/Sacondary (0-12) Collaga (1-4or 5+) Housewife Own Home 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Charles R. Gantz Helen Birney Gantz 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) PO Box 135 Valley Lee, Maryland 20692 Charle G. Crawford (son) 20b. Placa of Disposition (Nama of cematary, cramatory or other plece) 20a, Mathod of Disposition Data 20c. Location - City or Town, Stata permit. Peges
Depertment of
Important: If it
any injury or o 1 ☐ Burial 2 Crametion 3 ☐ Ramoval from State Metropolitan Crematory 5-25-98 Alexandria, VA 5 Othar (Specify) 21. Signatura 22. Nama and Addrass of Facility M00173 J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695 tar tha disaate, or complications that causad tha death. Do not enter the mode of dying, such es cardlec or respiratory arrest, heart failure. List only one cause on each line. Approximete Intarval Batween Onset end Daath Physician THE RUSCLERUTIC /Medicai Immediata Causa (Final disaasa or condition rasulting in deeth) Examiner Dua to for as e consequence of):
RDIOVASCULAR DISEASE Examiner The law requires that the death certificete be executed bunal-transit Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Ceusa (Disease or Injury that initiated avents resulting in daalh) Last Dua to (or as a consequence of) Box 68760. Physician/Medical the Dua to (or es a consequenca of): for use es P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? EREBRUVASCULAR DISTASE 1 Yes ZONO 3 Probably 4 ☐ Unknown Records. SEIZURE DISORDER 24a. Was en autopsy performad? 24b. Wera autopsy findings evallabla prior to completion of causa of death? 1 ☐ Yas 2 ☐ No of Vital Physicien: director, Be 25. Was case rafarrad to medical 26. Place of Daeth (Check only ona) 1 Yas 2 No Othar: Surring Home 5 Rasidance 8 Othar (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of Division or Attending 1 Delatural 2 Accidant 5 Panding Investigation 1 ☐ Yas 2 ☐ No death. efter death filled in by the 6 Could not ba 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 4 Homicida Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, dete end plece, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mannar stated. 29a. Certifian Medical completely (Check only one) \$ 29b. Signatura and titla of certifier 29c. Licansa number Allend 29d. Date signed (Month, Day, Year) 30. Name end addrass of person who completed cause of death (Itam 23a) (Type, Print) 303, Annual Completed Cause of death (Itam 23a) (Type, Print) 303, PRINCE FREDERICK ANWAR T. MUNSHI.MD PRINCE

State Registrar 31. Data filed (Month, Dey, Yaer)

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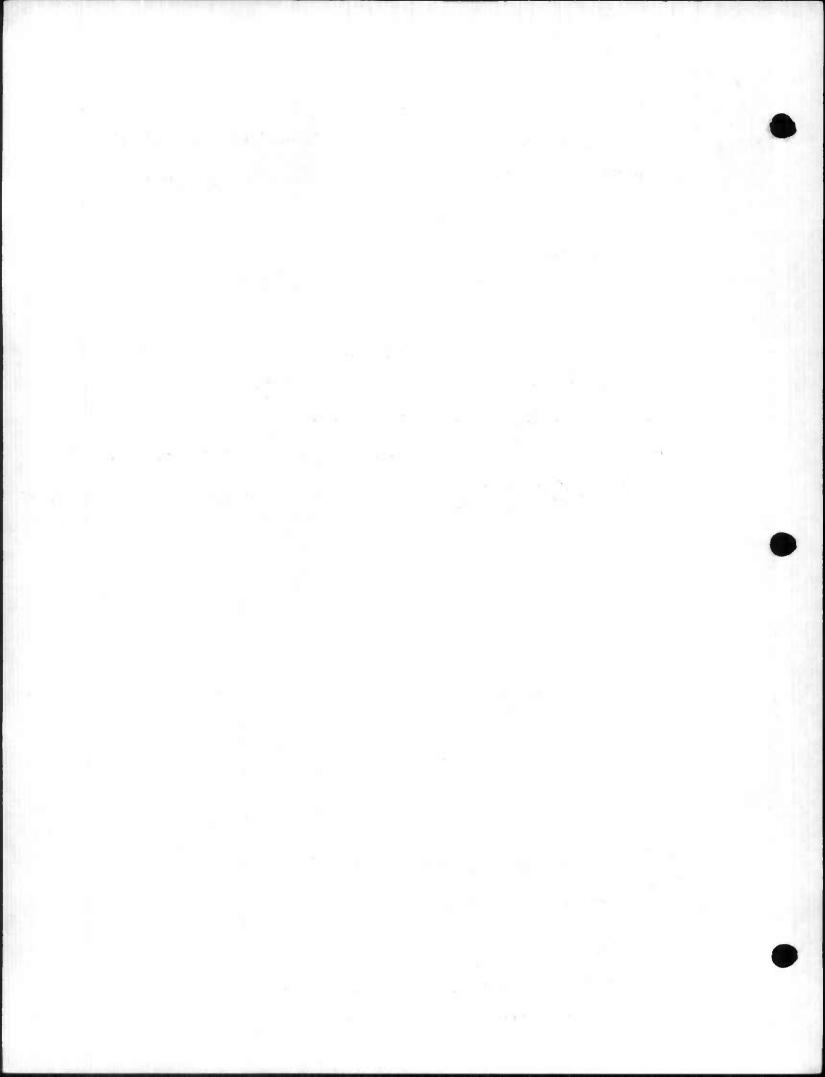
32. Registrar's Signatura



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State of Maryland / Department of Health and Mental Hygiene

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-	/Medi		JoAnn			tert	on					5:43 am
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	Funeral Director		213 64 2159	Sex 7. A	ge (In yrs. lest birthd 3 Yrs	Month	der 1 Yeer is Deys				9. Birthple Country MD	ce (Stete or Foreign v)
	Maryland H show	tor	Usuel Residence of Decedent 10e. Stete 10b. County MD Calver	:	10c. City, Town o Dunkirk						100	1. Inside City Limits 1 Yes 2X No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 2570 Chaney Ro	ad		10f.	Zip Code 2075	54		10g. Citizen of USA	What Country	n
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-4 show any Injury or other traumatic event, the Medical Examinat must be notined at once.	by Fune	11. Maritel Stetus 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces 1 Yes 2 4 If Yes, Give Yeer or Detes:	Ever In U,S.			Hispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	ce - American ck, White, etc. y:	
21215-0020	vithin 72 hone.	Completed by	15. Decedent's (Specify only highest g Elementery/Secondery (0-12)	Education rade completed) College (1-4or		ecedent's University of the control		oation during most of wo d)	rking	16b. Kind of B	usiness/Indu	
and 2	d be filed vantal Hygie and other to cevent, the	Be	10 17. Father's Neme (First, Middle, Last Thomas Nutwell P			ousew	110		me (First, Middle e Belle	, Maiden Suman		
Maryland	nd 2 shoul alth and Me 27 is mark r traumati	To	19e. Informant's Neme/Reletionship Raymond T. Catte	(Type, Print)	husb. 196. M	eiling Addre	ess (Street	and Number or Ri	ural Route Numb	er, City or Town,	State, Zip C	ode)
Baltimore,	Pages 1 and neut of Hee Int. if Item Irry or othe		20a. Method of Disposition 12 Cremetion 3 4 Donetion 5 Other (Special Control of Contro	☐Removel from Stete	20b. Piece of Di cemetery, Friend	cremetory o	r other ple	nurch	Dete 5-25-98	20c. Location Friend		
Balt	permit. Departr Imports any Inju		21. Signeture of Puneral Service to	DA.	2			ess of Fecility Funera	al Home	, Owin	gs, M	ID 20736
	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in deeth)		Due to (or es a con	VIRS	+	ng, such es cardie	c or respiretory e	orrest,	l Ir	oproximate ntervel Between Onset and Deeth
Box 68760,	eath certificate be assocuted attending physician and for use as the burial-transit	In/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b. Kuy	Due to (or es e con	sequence o	nfa!	rction				
P.O. B	that tha deat ed by the atte detached for	Physician/N	Pert II. Other significant conditions	contributing to death b	out not resulting in th	e underlying	g cause gi	ven in Pert I.		tobacco uss co Yes 2□ No		he cause of death?
Records, F	aw requires is been signs 2 should be	Completed by P							24a. Wes	en autopsy ormed?	24b. Were	e sutopsy findings eble prior to pletion of cause
E B		Com							10	Yes 24 No	101	Yes 25 No
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of	00	tion: To	1 Yes 2 No 27. Manner of Deeth 1- Naturel 5 Pending investigation	Hospitel: 1 Inpatie	ry 28b, Tim	e of	28c. Inju Wo			dence 8 Oth		
Division	To the Hospital or Attending Phy within 24 brours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident Investigation 3 Sulcide 8 Could not determine	28e. Pleca of In	ury - At home, ferm, c. (Specify)				28f. Location (City or To	Street end Numb wn, Stete)	per or Rural F	Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completaly filled in	edicai (29e. Certifier (Check only one) 1 Certifying P	hysician: To the best miner: On the basis o end menner st	f examinetion end/o	eth occurre r investigation	ed et the ti	me, dete end plece opinion, deeth occu	e, end due to the urred at the time,	cause(s) end me dete end place,	enner as stet and due to th	ed. ne cause(s)
	To th To th comp	M	29b. Signeture end title of certifler			2	_	se number		29d. Dete signe	d (Month, Da	ly, Year)
				- Muy			P4	5 235		5/23	198	
	17		30. Name and eddress of person who	Center BI	ND# 30	pe, Print)	Dun	Kirk, V	ND d	0754		
	Sta Registr	_	31. Dete filed (Month, Day, Year)	-/-	er's Signeture	Rad	12					



BLADAS AMBUA DAL

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** 7:00 AM MA) /Medical Gladys Amelia Dahl 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Lanham if Under 24 Hrs. Doctor's Hospital, Lanham Prince George's If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Functal Days Min. 1□ M 2X F Months Hours Yrs Director 87 579-28-6676 8/7/10 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Tyes 2 No Director MD Pr. George's Upper Marlboro 10e. Street end Number 10g. Citizen of What Country? Funeral 4810 Largo Road 20772 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Maritai Status 14. Race - American Indian. Biack, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Yes. Give 3√ Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementery/Secondary (0-12) Cottege (1-4or 5+) Registered Nurse Nursing Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be should be f PHarry Buck, Sr. Sarah Ball 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Laura Beall 4810 Largo Road, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Peges nent of h permit. Peges Department of Important: If Its any Injury or o 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 5/23/98 4 ☐ Donation 5 ☐ Other (Specify) Alex, Va. 22. Name and Address of Facility Raymond Funeral Home 23e. Pert : Egter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediete Ceuse (Final disease or condition resulting to death) Atherosclerotic treat Disease /Medical Examiner Thronic Ohstructive Pulmonary Distore Examiner nding physician and use es the bunel-transit Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thei initieted events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uaa contributa to the cause of death? P.0. Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24a. Was an autopsy 24b. Were autopsy findings Completed available prior to completion of cause of death? performed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Piace of Death (Check only one) Hospitei: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Dey Year) 27. Manner of Deeth he Hospital or Attending Pin 24 hours effer death.

The Funeral Director: After the pletely filled in by the funeral Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Maturet
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Phyalcian: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basts of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifler Medical (Check only one) within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) RA 14300 (32. Registrer's Signature GALLANT FOX LANE #222, BOWE, MD

Falis Davidson Randa

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95

State

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #2 WUHD 5/26/98 cle Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month LEE May 18, MARIAN 1989 440 A.M. **EDWARDS** /Medicai 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** At Home, 23540 Capitola Road Tyaskin

r If Undar 24 Hrs.
Hours Min. Wicomico 6. Sex if Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) 1□M 200 F Days Yrs. 220-32-2151 62 12/2/1935 Salisbury, Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes Director Md. Wicomico White Haven, Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23540 Capitola Road Funeral 21865 U.S.A.

14. Raca - American Indian,
Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Yaar or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Spacity: Specify: Black by 3 XWidowed 4 ☐ Divorced Completed 15 Decedent's Education 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry (Specify only highest grada completed) Coilege (1-4or 5+) Elementery/Secondary (0-12) 11 2 Editor Journalism 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be William James Wright Nora Wainwright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Benard Lionel Edwards, Husband Benard L. Edwards, 23540 Capitola Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Haven Cemetery 5/23 White Haven 21. Signature of Funaran Service Licansee 22. Name and Address of Facility Messee Messick Funeral Home , P.O. Box 61 Bivalve, Maryland 21814 and the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onsat and Death tmmediate Cause (Final 12 mo disaasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Couse (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Pert il. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? myelodysplustic Cyncherne 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy completion of causa of death?

Physician /Medicai **Examiner**

Funeral

Director

28a-f show must be notified at

ò items 23s

"natural", or

Peges 1 end 2 should be filed within a nent of Health and Mental Hygiene. Int: If Nem 27 is marked other than "r

permit. Peges 1 end 2 s
Department of Heath an
Important: if item 27 is a
any injury or other trau

traumatic event, the Medical Examiner.

the Meryland

72 hours after

Baltimore, Maryland 21215-0020

the burial-tran USB BS ettending p signed by the 6 peen page 2 s certificate

requires that the death certificate be executed

P.O. Box 68760.

Records,

of Vital

Division

Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, I

Examiner Physician/Medicai þ Be Completed

Certification: To

To the Hospital o within 24 hours aff To the Funeral DI completely filled in Medical Mora

25. Wes case referred to medical examiner? 27. Manner of Death

1 Yas 2000

5 Pending investigation

6 Could not be determined

1 Accident

3 Suicide

29e. Certitier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner es stated.

2 Madical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29b. Signature pertifier

28a. Date of injury (Month, Day Year)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Yes 2 No

28c. Injury at Work?

29d. Date signed (Month, Dey, Year) 5/20/98

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

28d. Describe how injury occurred

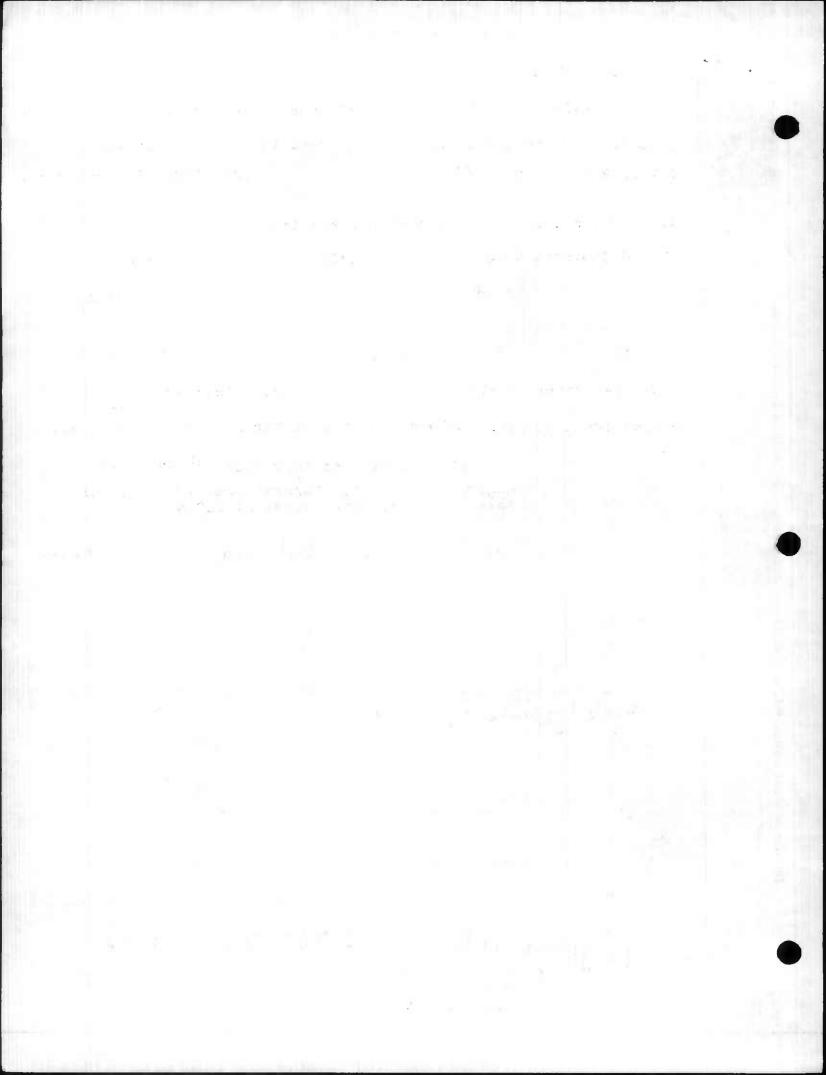
26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

30. Neme end all 31. Date filad (Month, Day, Year)

on who composed cause of death (Item 23a) (Type, Print)
CARROLL ST. SAUS BWRY 82, Begintrar's Signature MAY 2 0 1998

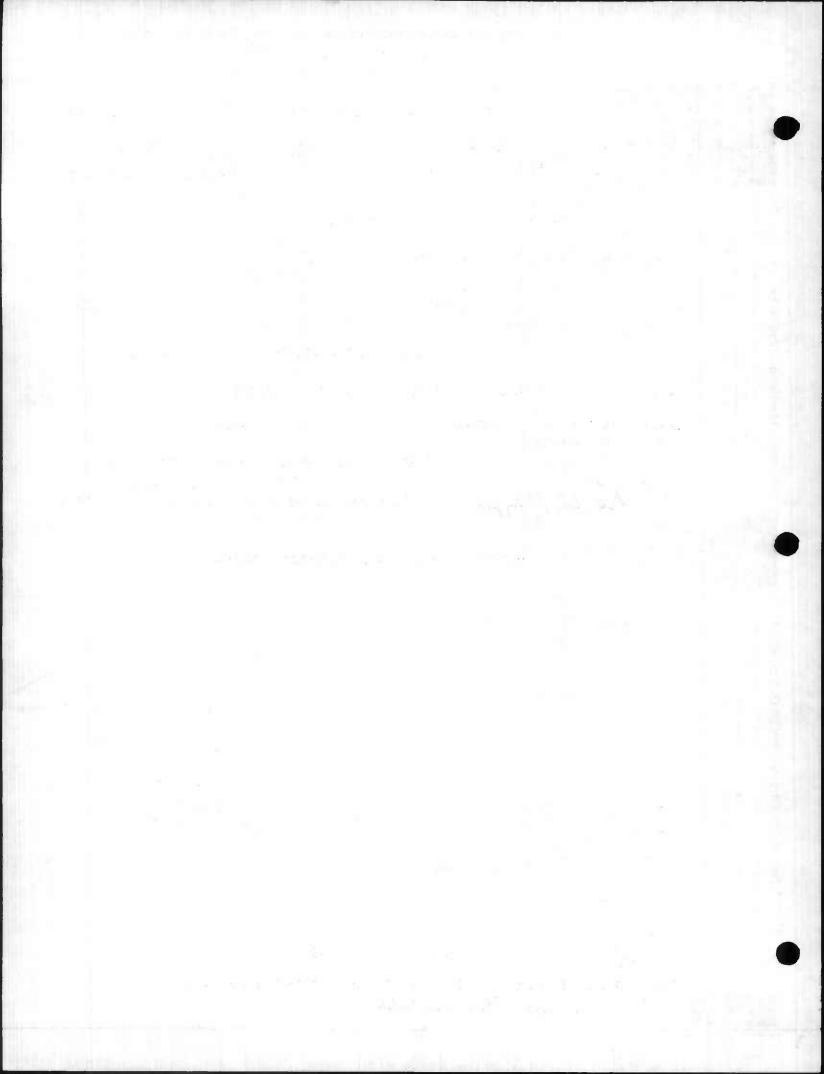
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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	Physici /Medio	_	Decedent's Name (First, Middle JOHN	e, Last)	TH	OMAS	FI	TZPATR	TCK	, JR.	2. Dete of D Month 05		Year 98	3. Time	e of Death
	Examin Funeral Director	_	4a. Facility Name (If not institution 1010 PARKWOOD 5. Social Security Number 219-14-1723	II 6. Sex	treet and nu	m <i>ber)</i>	n yrs. lest birth	if Under	der 1 Year	4b. City, Town, or SALISBURY If Under 24 Hrs	Location of Dea	th 4c. Count WICOI irth ay, Year)	y of Death	ace (Stat	te or Foreign
	τ		Usual Residence of Decedent			4/									
	faryla ed et	٥	Carlotte Co.	COM	T.CO		Oc. City, Town		TADI	(D)			10		e City Limits
	the h	rect	10e. Street and Number	.COM.	100				LISBU Zip Code	KI		10g. Citizen of	Whet Count	try?	
	h with	ai Di	1010 BEAGLIN	PARI	K DR.	APT	.# 204			21804		U	.S.A.		
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental thygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Example must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced		If Voe Gi	orces? 2 ☐ NdW	WII	If Yes, s	cedent of I pecify Cub	Hispenic Origin? (ean, Mexican, Pue Specify:	Specify Yes or N nto Rican, etc.)		ce - America ck, White, e		l _e
Maryland 21215-0020	2 hou		15. Deceden		ation	MA	RINES 16a. I	Decedent's U	sual Occu	pation	a de la a	16b. Kind of E			
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any	2 shou and M ia mar aumet	-	19e. Informent's Name/Relations							t end Number or F		ber, City or Town			
	es 1 and 2 of Health iftem 27 li r other tra		ZOE E. FITZPAT					7 ROCK		CT. Al	NNAPOLIS	T	1403		
Baltimore,	Pages 1 nent of H int: If ite		20e. Method of Disposition EN 1 ☐ Burial 2 ☐ Cremetion	3 □Re	MENT emoval from			, cremetory o	or other ple		Date	20c. Location	1		'
Hi	교원관금	1	4 □ Donation 5 ☒ Other (S 21. Signature of FunerabService		e		WICOMI			L PARK ess of Facility	5-20-98		SBURY,		
Ba	Depariment of the series of th		BK	1 1	00	·) (CESE			NERAL HO		05 E. MA ALISBURY			/.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complic	etions that on	caused the	death. Do no						, FID	Approxin	
	Physician /Medicai Examiner	ner	Immediate Cause (Final disease or condition resulting in deeth)	a.	ARTE		CLEROTI e to (or es e c			SCULAR D	ISEASE			Onset ar	nd Death
68760,	tificate be axecuted ig physician and as the burlal-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	с.			e to (or as a co								
Box	death certif e attending od for use a	an		d.									1		
0.	that the death led by the atter detached for	Physician/M	Part II. Other significant condition	ns cont	ributing to d	eath but n	ot resulting In	the underlyin	g cause gi	iven In Part I.	23b. Die	d tobacco use c	ontribute to	the caus	se of death?
S, P.	that the	by Ph					_				10	Yes 2 No	3 Prob	ably 4	Unknown
Records	e law requiras l has been sign ja 2 should be	Completed b										s an eutopsy formed?	con	ere autopa allable pri apletion d death?	sy findings for to of ceuse
	The ate h	Con									10	Yes 2 No	1 🗆	Yes 2	2□ No
Vital	Physician: The this certificate ral director, par	Be	25. Was case referred to medica examiner?	h.,	ospital:				Ot		eeth (Check only				
on of	ding Ph h. After th funeral	ition: To	1 ZXYes 2 No 27. Menner of Deeth 1 ZXNatural 5 Pendir 2 Accident Investi	9	28a. Date	Inpatient of Injury oth, Day Yo	2 ☐ ER/Out 28b. Ti n		28c. Inju	4 LI Nursing	Home 5 Per 28d. Describe	sidenca 6 ∐Ot e how injury occu)	
Division	is after death	Certification:	3 Suicide 6 Could 4 Homicide determ		28e. Place build	of Injury ing, etc. (S	- At home, fan Specify)	m, street, fac	tory, office			(Street and Num own, State)	ber or Rura	Route N	/um <i>ber</i> ,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifler (Check only one)	g Physi Examtn	ar: On the b	best of masis of ex	emination end	deeth occurr for investiget	ed at the ti ion, in my	ime, dete end plac opinion, death occ	ce, end due to the curred et the time	e cause(s) and m a, date and placa	anner as st , and dua to	ated. the caus	50(S)
	With To th	Σ	29b. Signature and title of certifie	_	STIPS -				29c. Licen	se number		29d. Date sign	ed (Month, I	Day, Yea	r)
	Δ	-	Johnne	3	المسد	سف	D.M.E		D035	99		05-15-9	8		
	GHVA		30. Name and address of person JOHN T. BULKELE		-				מבת	SALISBUR	אוכ שא א	801			
	Sta		31. Dete filed (Month, Dey, Year)		32.		Signature P		ו עמי	CURTOROK		.01			
	Registr	ar	MAY 1	3 199	18 /1	110									

DHMH 16 Rav 6/95



1. Decedent's Name (First, Middle, Last)

DARRON

4a Fscility Neme (If not institution, give street end number)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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te	of Maryland / Department of Health and Mental	Hygiene	1
	Certificate of Death	Reg. No.	-

, ,		C	Ω	17	2	6	
Reg	No.	1	0	1 1	0	U	J
2. Date of Death Month	Day		Year	3.	Time	of	Death

WORCESTER COUNTY

4c. County of Death

0909AM

1998

MAY 14,

4b. City, Town, or Location of Deeth

>		Physic /Med Exam	ical
		unera irecto	
020	urs after death with the Marylend	al', or items 23s or 28s-f show Exercises must be notified at	by Funeral Director

#9 BAY VISTA DRIVE BERLIN If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Months Days Hours 1 X M 2 □ F Yrs. 12 222-80-0837 Usual Realdence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 9 BAY VISTA DRIVE 21811 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced altimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Inportant: if item 27 is marked other than "natul
eny injury or other traumatic event, the Med call
page. 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) STUDENT 6 17. Father'a Neme (First, Middle, Last) LARRY J. GREEN 19e. Informent's Name/Reletionship (Type, Print) LARRY J. GREEN/FATHER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Ocremation 3 ☐ Removal from State SALISBURY CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of unoral Service Licenses 22. Name and Address of Facility Enely **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ASPHYYID **Examiner** Due to (or as a consequenca of) Examiner SMOTHERING AM STRANGULATIO certificate be executed ician and burial-trens Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): physician the burial Box 68760. Physician/Medical that initiated events resulting in deeth) Last Due to (or as a consequence of): 80 esn 0 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. signed by I Division of Vital Records. by Completed page 2 hes certificate or Attending Physicien: director, 25. Was case referred to medical examiner? Be Hospitel: 1X Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28b Time of 28c. Injury at Work? 28a. Dete of Injury (Month, Day Yeer) Certification: After GOY M 1 Netural 5 Pending 0 after death. Director: Aft 1 ☐ Yes 2 ☐ No 14 94 investigation 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours Hospital 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 29b. Signature and title of cartified 29c. License number O.C.M.E. 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signature

far barrieten Ra

LAWRENCE

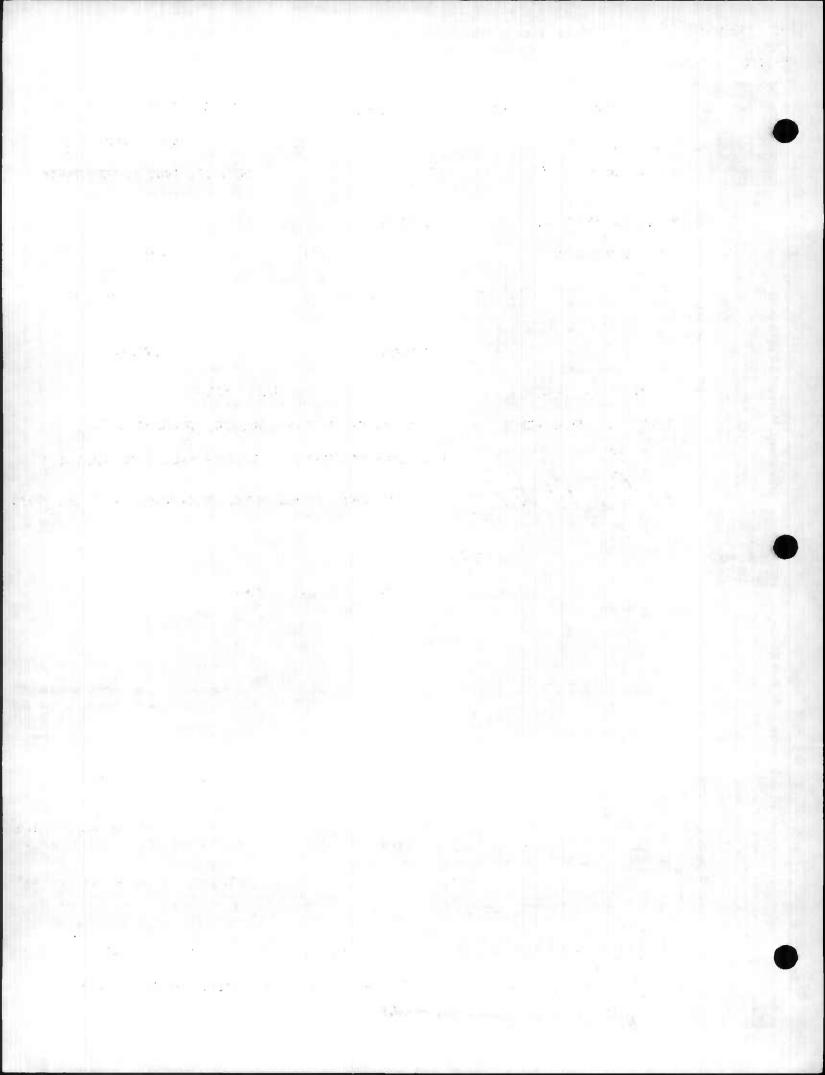
 Birthplace (State or Foreign Country) OCT. 28, 1985 PENNSYLVANIA 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry EDUCATION 18. Mother's Neme (First, Middle, Maiden Sumeme) KELLEY MAITHA 19b. Melting Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 9 BAY VISTA DRIVE, BERLIN, MARYLAND 21811 20c. Location - City or Town, State 5/17/98 SALISBURY, MARYLAND HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 Part / Enter the disease, or complications that could be deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on much line. Approximate Intervel Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Nes 2 No 1 Yes 2□ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 528 Residence 8 Other (Specify) 28d. Describe how injury occurred AND(ON) DROWN LETE FOUND WITH PLASTIC BAY OVER HEDD 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 9 BAY VISTA WORLES TEN GO 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) MAY 15, 1998 ALDRUS OURS A. KOREL HM. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

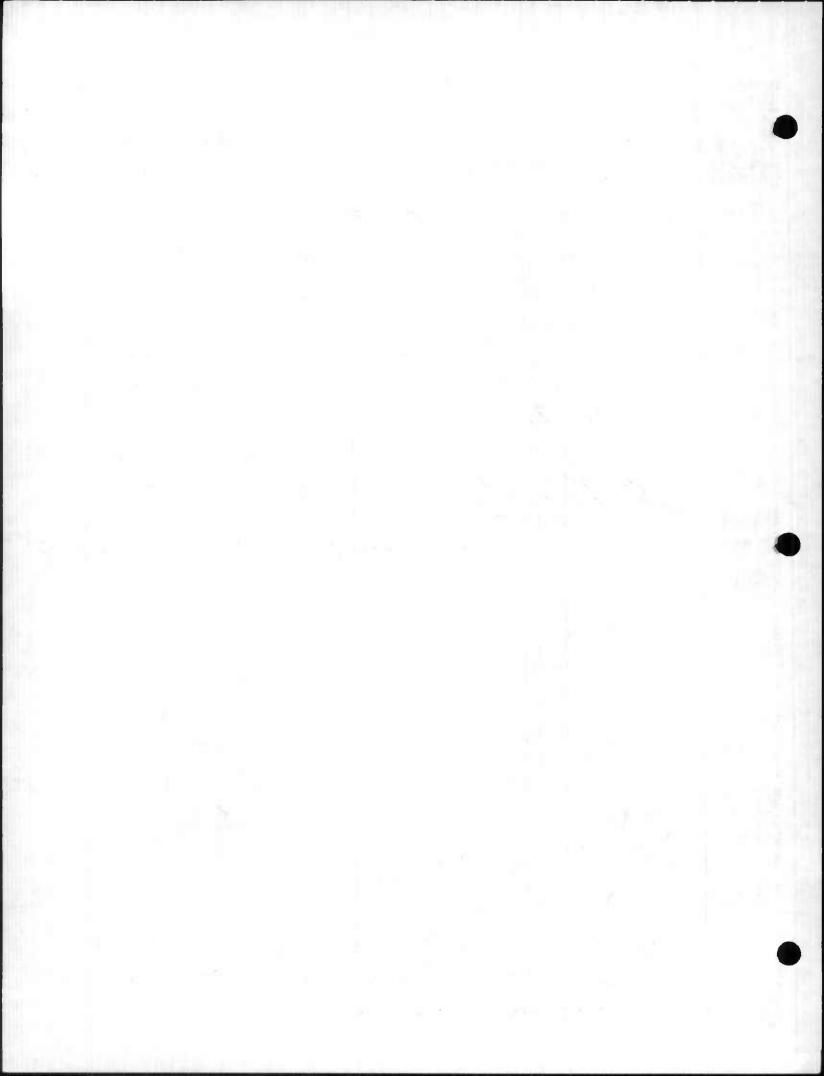
31. Dete filed (Month, Dey, Yeer)

181998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7 3 6 6 State of Maryland / Department of Health and Mental Hygiene

Physician		1. Decedant's Name (First, Middla, La	,	Tac		ficate of		2. Data of Deat Month	Dav	Yaar	3. Tima of Death
/Medical Examiner		Harry Lee I Ia. Facility Nama (If not institution, giv		Jr.			4b. City, Town, or	May 23, Location of Death	1998 4c. County	of Deeth	7:50 a.i
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Funeral Director		5. Sociel Security Number 6. S 579 40 8819	CXU off	(In yrs. las		if Under 1 Yee Months Days			Year) 1933	9. Birthp	laca (Stata or Fore try) Wash. I
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where sale or 28s-f shown in the sale of shown in the sale of the	מו הו	10e. Street and Number 3816 16th Street				10f. Zip Coda	732	1	0g. Citizan of V	Vhat Coun	try?
ar, or items	2	11. Marital Status 1 Navar Married XX Marriad 3 Widowed 4 Divorced	12. Was Decedant E Armed Forces? DOVas 2 □ N If Yas, Giva Yaar or Datas:			s Decedent of as, specify Cu Yas 25 No	Hispanic Origin? (Span, Maxican, Puar Specify:	Specify Yas or No- to Rican, etc.)	Blac	a - Amaric k, Whita, .whit	atc.
tal Hygiane. d other than "nature event, the Medical Be Completed	Displace	15. Dacadant's Ec (Spacify only highast gra Elementary/Secondary (0-12)	ducetion ide completed) Collega (1-4or 5-		16a. Deceder (Giva kir life. DO Pressi		ipation a during most of wo ed)	orking	16b. Kind of Bu	siness/Ind	
ed other e event, l	200	17. Fether's Name (First, Middla, Last) Harry Lee Hil						ma (First, Middla, M en Marie	Maidan Sumam	a)	
th and Men 7 is marked traumatic	-	19a. Informant's Name/Ralationship (Mary L. Hilton/w	Type, Print)	Si	19b. Mailing . ame as	Address (Stree	at and Number or R	ural Routa Number	, City or Town,	State, Zip	Code)
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Departruimporta any inju		21. Signature of Funeral Service Bour	Of Oron			lama and Addi		ome, Owin	ngs, MD	207	36
hysician /Medical xaminer		Part1. Enter the disease, or com shock, or heart fallure. List only Immediate Cause (Final disease or condition resulting in death)	a Co/	01		NCEV		,			Approximata Intarval Batween Onsat and Death
ing physician and e as the bunat-transit	Medical Evalua	Saquantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disassa or Injury that initiated evants rasulting in death) Last	c		s a conseque						
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igned by the attendir be detached for use by Physician/	1193	Part II. Other significant conditiona c	ontributing to death bu	t not resulti	ing in the unda	artying causa g	ivan In Part I.	23b. Did to	./	tributa to 3□ Prof	the cause of deal pably 4 - Unknown
sate has been signe, page 2 should be d								24a. Was a perform		ava	ere autopsy finding allable prior to mplation of cause death?
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s certificate director, pag To Be Co) I	25. Was case refarred to medical axaminar? 1 ☐ Yas 2 M No	Hospital:	t 2□ FF	R/Outpetient	3□ DOA O	26. Place of De thar: 4 ☐ Nursing I	Homa 5 Basida	a) inca 8 □Oth	ar (Snecifi	v)
ftar this	• -	27. Mannar of Death 1 Natural 5 Panding 2 Accidant invastigation	28a. Data of Injury (Month, Day	/ 2	8b. Tima of Injury	28c. Inj		28d. Describe ho			<u>'</u>
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At hom (Specify)	a, farm, streat	t, factory, office	1	28f. Location (St City or Town	raat and Numb n, Stata)	er or Rura	l Routa Number,
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To the comp		29b. Signature and title of certifier	Silver,	ast)		ise number 3	2	9d. Date signed	Month,	Day, Year)
1	\perp	30. Nama and addrass of parson who							-		



Pages 1, 2, 3 should

permit.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL ORRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the b		
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within 24 h	pletely filled	cremation, (ent, the r
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the death of	the attend	d Mental H	Injury, or
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The law re-	te has been	ste Dept. or	em 23 sh
HYSICIAN:	his certifica	with the St	ked, or it
TENDING P	TOR: After 1	after death	28 is mar
ITAL OR AT	RAL DIRECT	72 hours	: If item 2
TO THE HOSP	TO THE FUNE	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle, Legs) 2. DATE OF DEATH 3. TIME OF DEATH Hill May 16, YEAR 11:36 A. M 7. DATE OF BIRTH
(Month, Dec Year)
Oct. 6, 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. DAYS 424-20-3043 1 M 2 X Alabama 9a. FACILITY, NAME (If not institution 96. CITY, TOWN OF LOCATION OF DEATH 9c. COUNTY OF DEATH 616 Canden Salisbury Wicomico DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Virginia Accomack hinco teague 1 1 YES 2 | NO FUNERAL 100. STREET AND NUMBER 101. ZIP CODE 10g., CITIZEN-OF WHAT COUNTRY? 5077 (hicken (ity Road u. J. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian Black, White, atc. Specify: White 1 Never Merried 2 Married BY 3 Wildowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.)

HOMEMAREL Elementary/Secondary (0-12) College (1-4 or 5+) Self COMPL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Persons Unn 8 180. INFORMANT'S NAME (TOPPFINE)
RICHARD A. HOOKS 1910. MAILING ADDRESS (Strong and Number or Rugal Agute Number 6/6 (anden Ave. Sausbury) City or Town, State, Zie Code 201801 2 20s, METHOD OF DISPOSITION
110 Burlel 2 Cremetton 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Virginia 5-19-98 Oak Hall. emetery 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. GANELANDADOFESTALESCUTY Home (hincoteague, Virginia 23336 23. PART I. Enter the diseases, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Finsl Onset and Death disease or condition_ resulting in death) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL 1 TYES 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\beta \) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one EXAMINER? HOSPITAL: OTHER:
4 Nursing Home 5 Residence 1 YES 2 1 Inpetient 2 ER/Outpetient 3 DOA 6X Other (Specify) HOSPICE Coaste 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending м 1 YES 2 NO ВУ Investigation 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER (Check only one) MEDICAL EXAMINER: On the basis 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d DATE SIGNED 8 04822 9 . NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Herton

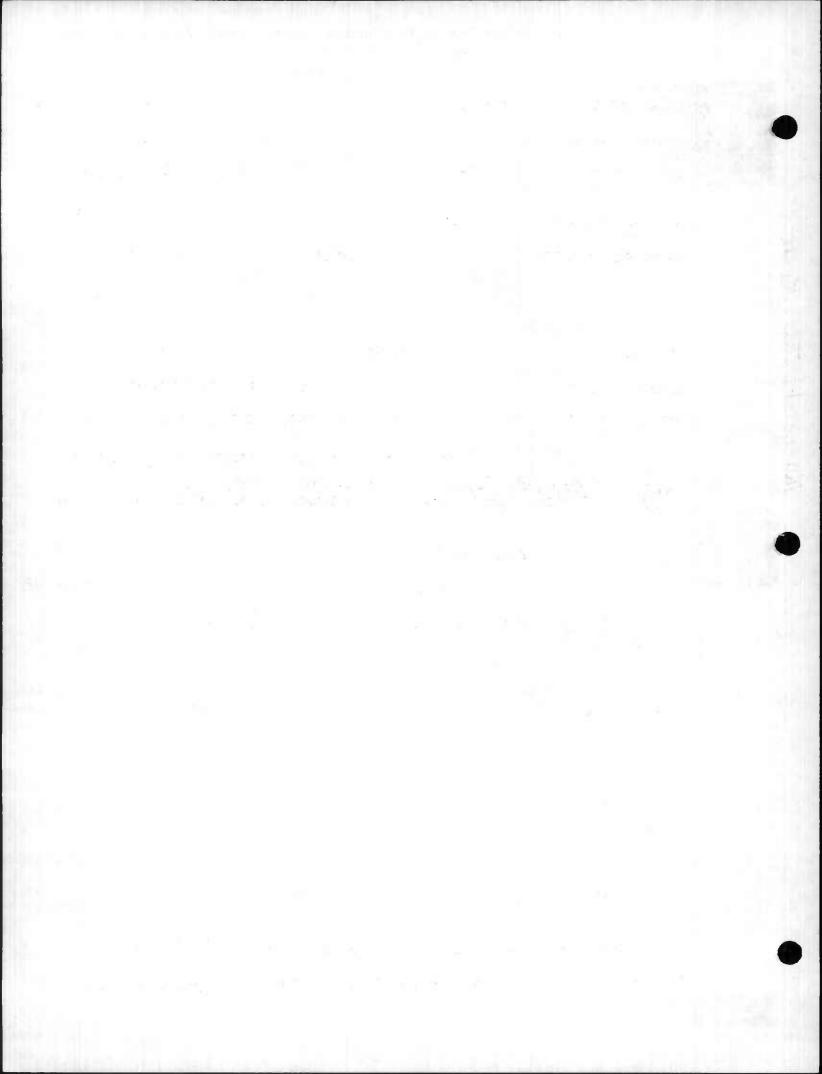
32. REGISTRAB'S SIGNATURE

4 _

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

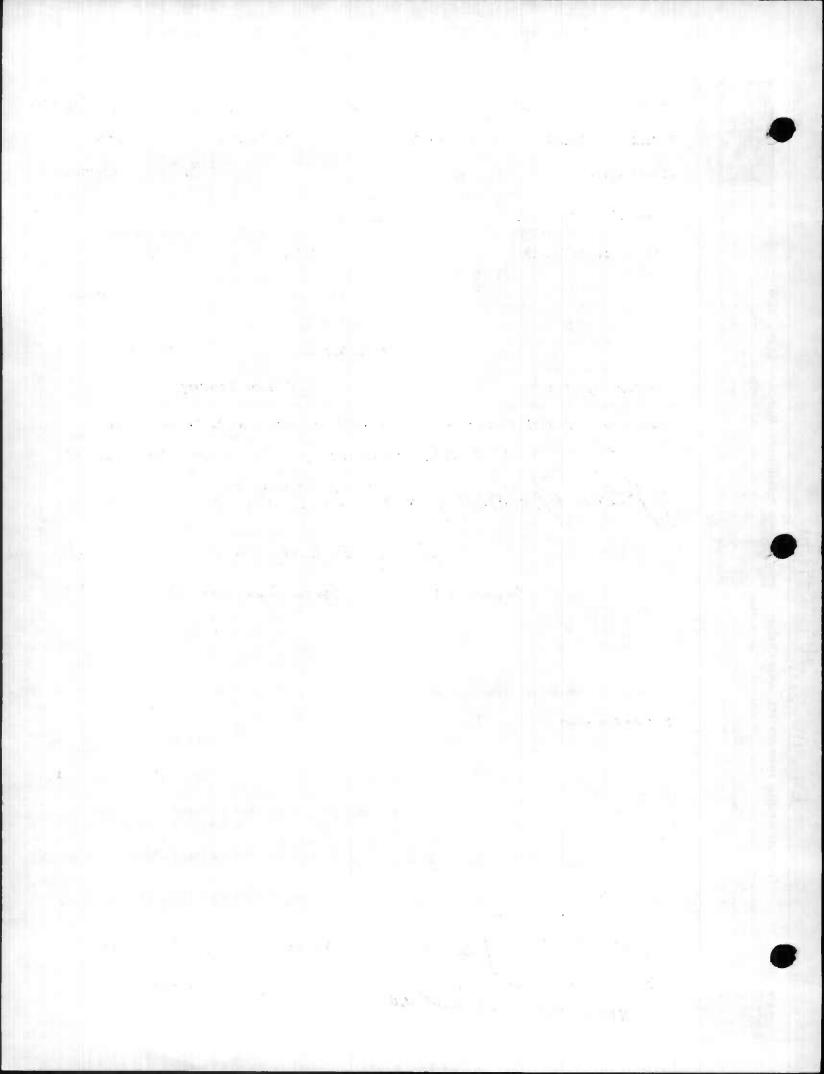
					State of I	viaiyiai		tificate of			gierie leg. No. 9	3 1	7365	2
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	Physici /Medio		MARGARET ES	STELLE	BAKER K	NOTT				May 2	21, Dey 1998	Year	7:10A	M
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	Funeral Director		5. Sociel Security Number 214-32-9768 Usuel Residence of Deced		м ЖЖг /.	75	lest birthday) Yrs.	Months Deys	Hours Min.		, 1923	9. Birthpi	lece (Stete or Fo	oreign
	DO M M			County		10c. Cit	ty, Town or Lo	cation				10	0d. Inside City Li	imits
	rith the Maryla or 28a-f show be notified at	tor	MARYLAND CHA	ARLES		NE	WBURG						1 Yes 2	.] No
Ş	with the M a or 28a-f be notifie	Director	10e. Street end Number					10f. Zip Code			10g. Citizen of V	/hat Coun	try?	
ž	20 100 110		14495 FOREST	C DRIVE	2			2066	4		UNITED	STATI	ES	
21215-0020	72 hours after death natural, or items 23 disal Examiner must	by Funeral	11. Maritel Status 1 Never Married 2[3 Wildowed 4 Dir	Married	12. Wes Decede Armed Force 1 ☐ Yes 2 [If Yes, Give Yeer or Dete	ANo		Vas Decedent of H Yes, specify Cuba	lispenic Origin? (S an, Mexican, Puer Specify:	specity Yes or No- to Rican, etc.)		- Americ k, White, o	etc.	
35		eted	15. De (Specify only	cedent's Educ	cation completed)		16a. Deced	ent's Usuel Occup	etion during most of wo	rkina	16b. Kind of Bu	siness/Inc	lustry	
32	Hygiene. Hygiene. Ther then and, the Me	Be Completed	Elementery/Secondary (College (1-4d	or 5+)		kind of work done OO NOT use retired USEWIFE	3)		HOMEM	AKER		
	be filed tai Hygie d other event, th	ပိ	17. Fether's Neme (First, A	Aiddle, Last)			noc	DLWILL	18. Mother's Ne	me (First, Middle,				
a la		To B	HARRISON BAI	KER						ICTORIA		•		
Maryland	d 2 th ag		19a. Informent's Neme/Re THERESA COLI		pe, Print) JGHTER			g Address (Street FOREST D					Code) 564	
Baltimore,	or the tr		20e. Method of Disposition	ation 3 R	emovei from Ste	te	cemetery, crem	sition (Neme of netory or other plea		Dete 5/27/98	20c. Location -			
量	Department Important: any Injury		4 Donetion 5 Of		0 / 0	HO		ST CHURCH				MARII	AND	
Ba	Dep Person		Mydial.	THORNTO	ON JOHNS		0583 34	Name and Addre HORNTON F 39 LIVIN	GSTON RO	AD, INDI	AN HEAD	, MD	20640	
			23a. Pert1. Enter the diseashock, or heert feilure	ese, or compli e. List only on	cetions thet caus le cause on eech	sed the deet n line.	h. Do not ente	er the mode of dyir	ig, such es cardia	c or respiretory en	rest,		Approximete Interval Betwee Onset and Deel	in ith
í	Physician /Medical Examiner		Immediete Ceuse (Finel diseese or condition	e	PNEL	IMON	111						3-4 mos	
	LAGIIIIICI	-	resulting in deeth)				or es e conseq	,					2 11	71.
	ned neit	Examiner		_ b	CAK			THE L	UNG				3-4 Moi	rus
ć	exacu in and riel-tra	Exa	Sequentially list conditions if eny, leeding to immediat cause. Enter Underlying	e	CHA		or es e conseq	uenca of): TRUCTI	15 1	n Die	CAT P		3 vent	rs
68760,	The law requires that the deeth certificate be executed tite has been signed by the ettending physician and page 2 should be detached for use es the buriel-transit	edical	Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest	1 °	LITE		or as e consequ		L Loui	06 213	enso			
Box	ettending for use e	Physician/M		d								-		
	deet he ett	sicie	Pert II. Other eignificant co	onditions con	tributing to death	but not res	ulting in the ur	derlying cause giv	en in Pert I.	23b. Dld to	obaçeo usa cor	tributa to	the cause of de	eath?
P.0	d by the de	Phy	Hypert	ensin	^					1081	88 2 No	3 Prot	ebly 4 Unk	known
ds,	ires thei signed t	d by										245 18/4	re sutency tindi	inne
Sor	v require been si should	Completed								perfor	en eutopsy med?	ave	ere autopsy tindi elleble prior to mpletion of caus	
Re	The law cate hes	duc								40.4			death?	
tal		Ö	25. Wes case referred to 1	nedical					GC Place of Do	1 □ Y eth (Check only o		14	Yes 2 No	
>	ysician: s certifica director,	To Be	examiner? 1 ☐ Yes 2 ☑ No		ospitel:	atient 2	ER/Outpetien	t 3 DOA Oth	or:	fome 5 ☐ Resid		er (Specify	()	
0	Ph er thi	- uc	27. Menner of Deeth 1 ☑ Neturel 5 ☐ I	Pending	28e. Dete of I		28b. Time of Injury	28c. Injur Wor		28d. Describe h			,	
Siol	eath. or: Af the fu	catlo	2 Accident	nvestigetion Could not be		, ,	,		Yes 2 □ No					
Division of Vital Records,	s after d	Certification:	3 ☐ Suicide 6 ☐ 6 4 ☐ Homicide	determined	28e. Pleca of building,	Injury - At he etc. (Specif	ome, ferm, stre y)	et, factory, office		28f. Location (S City or Tow	itreet end Numb n, Stete)	er or Rura	l Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical	29a. Certifier 1 ☐ Ca (Check only 2 ☐ Ma	rtifying Phys idical Examin	ician: To the besis	of exemine	wledge, deeth tion end/or inv	occurred et the tir estigetion, in my o	ne, date end pleca pinion, deeth occu	a, end due to the d urred et the time, d	euse(s) end me date end place, a	nner es st and due lo	eted. the cause(s)	
	vithir To th	Σ	29b. Signeture end title of		1			29c. Licens	e number		29d. Dete signed	(Month, i	Dey, Year)	
			aurerio	C.de.	le for,	H.D.		D/6	160(H.	my land)	05-1	1-98	>	
			30. Name and address of p Aurelio De 1	erson who co	mpleted cause of MD 128 1	f deeth (Iten Route	n 23e) (Type, I 6 West	Print) ,P.O. Bo	x 1230.L	a Plata.	Marvland	1 206	46	
	Sta Registr		31. Dete filed (Month, Dey, MAY 2	^{Year)} 199	8 32. Regi	strar's Signa	ture Lor Rad	м	,					

DHMH 16 Rsv 6/95



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		Certificate of Death	Reg. No. 9	1/369
6 1	Decedent's Neme (First, Middle, Last)		2. Dete of Deeth Month Dey	Yeer 3. Time of Deeth
Physician /Medical	EDNA EARLE	MARZONI	MAY 18 19	998 0846
Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Deeth 4c. County	of Death
	PENINSULA REGIONAL MEDICAL CENT		BURY WIC	OMICO
Funeral Director	5. Sociel Security Number 417-40-4341 Usuel Residence of Decedent 6. Sex 1 □ M 2 ▼ F 66	ast birthday) Yrs. If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min.	8. Dete of Birth (Month, Dey, Yeer) 4/11/32	Birthplece (State or Foreig Country) Alabama
ž ==	The state of the s	, Town or Location		10d. Inside City Limit
or 28s-f sh be notified a	Maryland Wicomico	Salisbury		1 ☐ Yes 2 🕅 N
23a or 2 ust be n	10e. Street end Number 1143 Nevins Place	10f. Zip Code 21804	10g. Citizen of W USA	
rat, or items 23a or 28a-f show Examiner must be notified at 1 by Funeral Director	11. Maritel Stetus 1 Never Married 2 Merried 3 Widowed 4 25 Divorced 12. Wes Decedent Ever in U,s Armed Forces? 1 Yes, 2 X No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispenic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.) 14. Race Blect Specify:	e-American Indien, k, White, etc. White
lai Hygiena. d'other than "natural", event, tre Mexical Eu Be Completed by	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usuel Occupetion (Give kind of work done during most of work	ina 16b. Kind of Bu	siness/industry
up du	Elementery/Secondery (0-12) College (1-4or 5+)	life. DO NOT use retired)		
Co	12 4	Teacher/Librarian	Educa	
d oth	17. Fether's Neme (First, Middle, Last)		e (First, Middle, Maiden Sumem	θ)
marked o	Grover Greene	Mildred	d Bradley	
and sum sum	19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Run	al Route Number, City or Town,	State, Zip Code)
Department of Haalth and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Manage. To Be Compl	A D Books O STOrementer 2 D Doministra Character	1143 Nevins Place, Sa ece of Disposition (Name of emetery, cremetory or other place) isbury Crematory	Dete 20c. Location -	804 City or Town, Stete
e attending physician and ad for use as the burial-transit sician/Medical Examiner	Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that britished graphs.	es e consequence of): Pertral Nervous System Degen es e consequence of): es e consequence of):	enative dr.	35%
the alle obed for ysicia	Pert II. Other significant conditions contributing to death but not resu	ilting in the underlying cause given In Pert I.		ntributs to the cause of dea
detact by APh	Hypotensian		1 Tyss 2 200No	3 Probably 4 Unkno
cate has been signed by the attend page 2 should be detached for us Completed by Physician/			24a. Wes en eutopsy performed?	24b. Were autopsy finding eveilebie prior to completion of cause of death?
certificate has rector, page 2 Be Comp			1 ☐ Yes 2 X No	1 □ Yes 2 No
to to	25. Wes case referred to medical	26. Piece of Deel	h (Check only one)	
	examiner? 1 Yes 2 No Hospitei: 1 Inpatient 2 I	Other	ome 5 Residence 6 □Oth	er (Specify)
death. Hors After this y the funeral of Ication: To	27. Menner of Deeth 1 Naturel	28b. Time of Injury et Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurr	
olivectors of in by the ertifica	4 Homicide determined 28e. Plece of Injury - At hobiding, etc. (Specify	me, ferm, street, factory, office	28f. Location (Street end Numb City or Town, State)	er or Hurer Houte Number,
EM O		viedge, deeth occurred et the time, date end piace,		
n 24 hours after the Funeral Dis- pletely libed in edical Cert	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinel end manager stated.	ion endor investigation, in my opinion, doesn't decid		
within 24 hours after death. To the Fuveral Director: After to completely filled in by the funeral Medical Certification:	(Check only 2 Medical Examiner: On the basis of examinet	29c. License number	29d. Date signed	d (Month, Dey, Year)
within 24 hours a To the Funeral D completely filled Medical Ce	(Check only one) 2 Medical Examiner: On the basis of examinet end manner stated. 29b. Signeture end title of certifier	29c. License number	29d. Date signed	d (Month, Dey, Year)
	(Check only one) 2 Msdlcal Examiner: On the basis of examinet end manner stated.	29c. License number D 2 4 9 8 G 23a) (Type, Print)	5/18/	d (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician GEORGE MEDEIROS** 1998 R. 4b. City, Town, or Location of Death 2100 * /Medical 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 2 if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthdey) 9. Birthplaca (State or Foreign 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 1⊠M 2□ F Yrs. 79 JULY 16,1918 MASSACHUSETTS **Director** 032-07-8888 0 Usual Residence of Decedent the Maryland 10e. Stata 10c. City, Town or Location 10d. inside City Limits 10b. County ir than "natural", or itema 23a or 28a-f show the Medical Example: must be notified at 1 ☐ Yes 2 No Directo WICOMICO DELMAR 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 DOWNING RD. 21875 32676 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 Styles 2 NoWWII If Yes, Give Year or Dates:MARINES 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 LETTER CARRIER POST OFFICE other traumatic svent. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be should be ind Mental I JOSEPH **MEDEIROS** GUIOMAR **PACHECO** F. MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health an Important: if item 27 is many injury or other 900ce. DELMAR, MD VIRGINIA E. MEDEIROS - WIFE 32676 DOWNING RD. 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State SPRINGHILL MEMORY GARDENS 5-19-98 22. Name and Address of Facility 705 E. MAIN ST. SALISBURY, MD 21804 BOUNDS FUNERAL HOME round Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Betw Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) MYOCARDIAL Examiner Examine ician and burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician the burta Box 68760, Physician/Medical Due to (or as a consequence of) 2 887 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ad by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 븄 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 86 26. Piace of Deeth (Check only one) examiner? 105 Yes 2 □ No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 4 unersi 27. Menner of Death
Natural
2 \sum Accident 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 5 Pending Investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not ba determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide ŏ 24 hours • Funeral Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

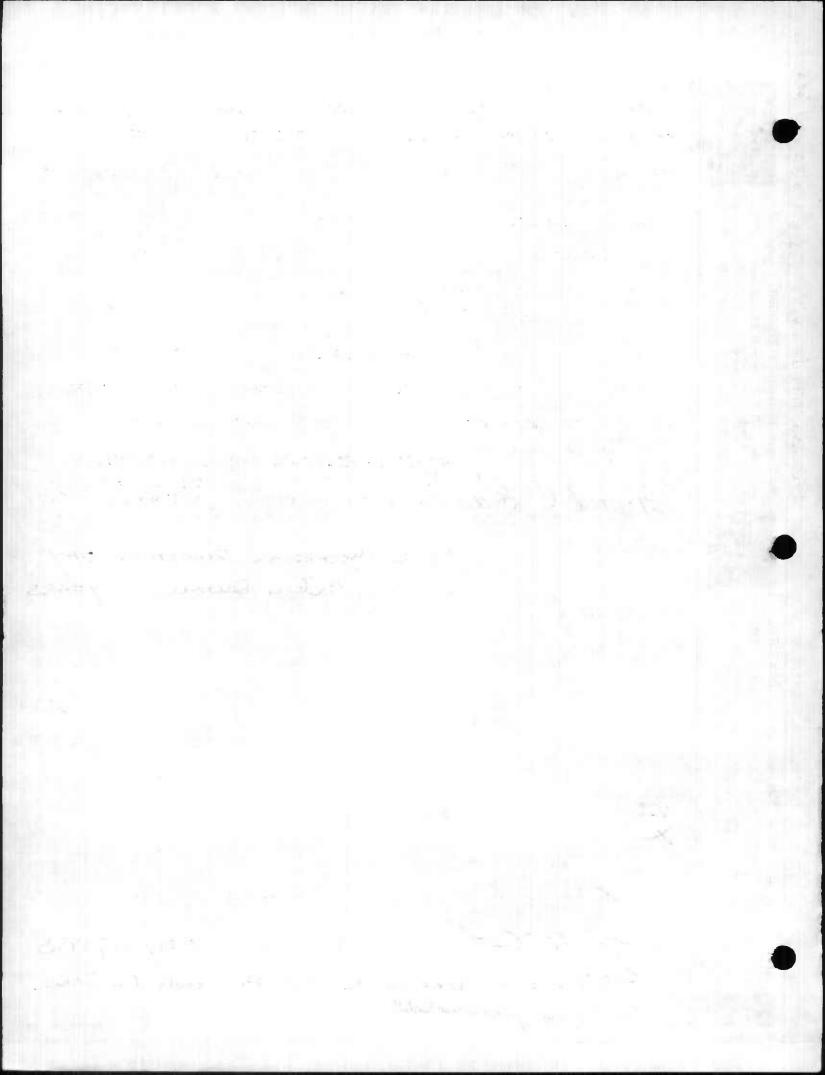
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the Within 2 To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of pertifier D36576 30. Name and indress of person who completed cause of death (Item 23a) (Type, Print) TRAVITZ MD 560 Ruescole De SAGIS Registrar's Signature h. Day.

DHMH 16 Rev 6/95

State

Registrar

MAY 181998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death **Physician** Month MAY 20, ARMOND NEIL 1998 14:56 pm /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert if Under 1 Year Hunder 24 Hrs. 8. Data of Birth Months Days Hours Min. July 26, 1929 7. Age (In yrs. last birthday) Birthplace (State or Foraign PA 5. Social Sacurity Number **Funeral** 1 M 2□ F 68 173 22 0983 Yrs. Director Usual Rasidance of Dacedent the Meryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Calvert Dunkirk 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 9617 Cortland Lane 20754 USA permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: if flem 27 la marked other than "natural". The page of the traumatic events once. Funerai t2. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. t Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 1948—50 white 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesman food brokerage 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Armond Neil Georgia Lucina Tucker 19a Informant's Name/Relationship (Type, Print) Patricia A. Neil/wife 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) same as 10 above 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 5-21-98 Alexandria, VA Metroportan Crematory 1 ☐ Burial 2 ♣ Cramation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funaral Survice Lineman 22. Nama and Addrass of Facility Rausch Funeral Home, Owings, MD 23a. Part1. Enter the disease, or complications that carried shock, or heart failure. List only one cause on smith lin death. Do not anter the mode of dying, such as cardiac or respiratory errest, Approximate interval Between Onsat and Death Physician /Medical Immadiate Causa (Final Acute Myocadial Infaction
Dua to (or as a consequence of): Examiner Cadio vascula Disease Physician/Medical Examiner physician and s the buriel-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Records, P.O. Box 68760, Due to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? Yee 2 No 3 Probably 4 Unknown I Dabetes; Cerebourseula assasi should be det þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy Adaminal Asty Aneurson completion of cause of death? 1 Yes 2 No t ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to Be 25. Was cese refarred to medice! examiner? 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Data of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No invastigation 2 Accident 3 Suicide 6 Could not be datarmined 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, tarm, street, factory, offica building, etc. (Specify) 4 Homicide Descripting Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Cartifian 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 033123

1 JP 10

> State Registrar

▶

JONATHAN D. LOWENTHAL, M.D. 31. Data filad (Month, Day, Year)

30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print)

PRINCE FREDERICK, M.D.

32. Registrar's Signature MAY 22 1998 > Falis Davidson Ravlall

DHMH 16 Rev 6/95

Y AAR C

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Dev **Physician** Month Yeer Judy Ann Niland 4e. Feclity Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death /Medicai 0042 Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthpiece (State or Foreign Funeral Days Hours 1□M 2□F 579 54 0430 1942WashingtonDC 55 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "nature" any injury or other traumetic even. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Calvert North Beach 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? 7032 Myrtle Ave 20714 United States Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married white 1 Yes XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) legal secretary Law office 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Maurice McDonald Thelma Stephens 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles F. Niland Sr. 7032 Myrtle Ave. NorthBeach Maryland 20714 20b. Plece of Disposition (Neme of cemetery, crematory or other plece May 22, 1998 Lexington Park MD Immaculate Heart of Mary 20a. Method of Disposition 1 XBuriel 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. POrt Republic MD 2068 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death Physician Breast Cancer, metastatic /Medical Immediete Cause (Final diseese or condition resulting in death) 2 years Examiner Due to (or as a consequence of): Examiner attending physician and for use es the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): 98 Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel exeminer? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deetl Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No 2 Accident

Division of Vital Records, P.O. Box 68760. that the death certificate be I or Attendin efter death. Director: Afr To the Hospital within 24 hours a To the Funeral

6 Could not be determined

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Descripting Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and menner as steted.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and manner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signe

31. Dete filed (Month, Dey, Year)

3 ☐ Suicide

29e. Certifier

4 Homicide

29c. License number

29d. Dete signed (Month, Day, Year)

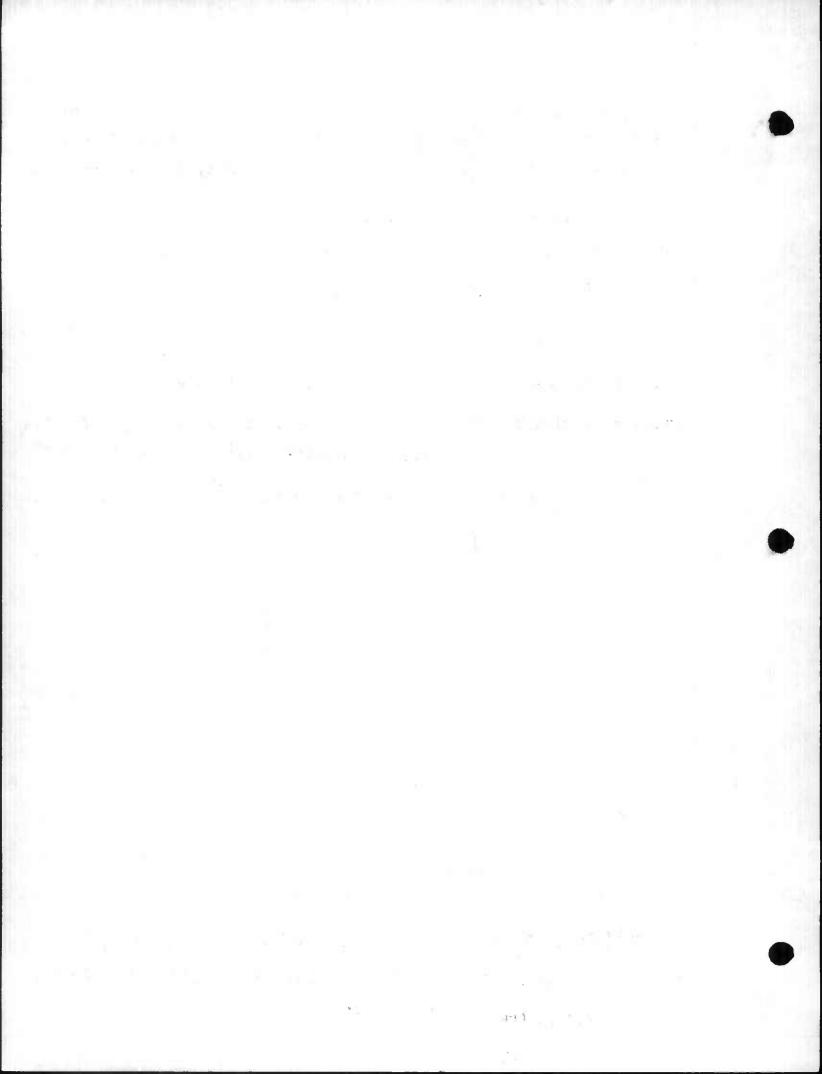
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Bestgate Annapolis, Md. selonich, m, o

, do

State Registrar

edicai

-82. Registrer's Signature John Sanden Roslall



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State of Maryland / Department of Health and Mental Hygiene

efter death with the Maryland	Physicia					Cer	tificate of	Death		Reg. No.		1010
Q Z1Z15-UUZU Illed within 72 hours effer death with the Maryland Lygiene.	•	an	Decedent's Name (First, Midd	dle, Last)		_			2. Dete of De Month	Dev	Yeer	ime of Deeth
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C Z1Z15- filed within 72 Hygiene.	al', or Items 23a or 3 Examiner nast be n	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Me 3 ☒ Widowed 4 □ Divorce	rried Armed For	2 🕅 No	3. 13. V	Vas Decedent of I Yes, specify Cub X Yes 2 No	Hispenic Orlgin? (Spen, Mexican, Puer Specify: Pue Ric	rto		e - American Ind k, White, etc. : Hispan:	
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00 C	mark umati	ř	19e. Informent's Name/Reletion	ship (Type, Print)		19b. Mailin	g Address (Stree	t end Number or R	ural Route Numbe	er, City or Town,	State, Zip Code,)
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mit. F	돌흥를		21. Signature of Funerel Service				Name end Addr		ewell Fu	meral H	ome	
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lor Attending efter death.	Director:	Certification:	3 Suicide 6 Could	not be 28e. Plece	of Injury - At honing, etc. (Specify)	ne, ferm, stre	et, fectory, offica	7100 2 2 110	28f. Location (: City or Tox	Street end Numb vn, Stete)	er or Rurel Rout	e Number,
To the Hospital or Attending Physician: within 24 hours efter death.	E 9	edical C	(Check only 2 Medical	ng Phyalcian: To the l Examiner: On the ba	sis of examinetic	rledge, deeth	occurred et the ti	me, dete end plece	e, end due to the urred et the time,	ceuse(s) end me dete end pleca,	nner es steted.	
To the	• Fundietely 1	고	one)	end menn	er stated.		estigetion, in my					euse(s)
	writing a nous enter logari. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Med	29b. Signeture end title of certific	ena menn	er stated.			se number		29d. Dete signe	d (Month, Day, Y	'ear)
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32. Registrar's Signeture

MAY 21 1998 > July Sunder Randall

State Registrar

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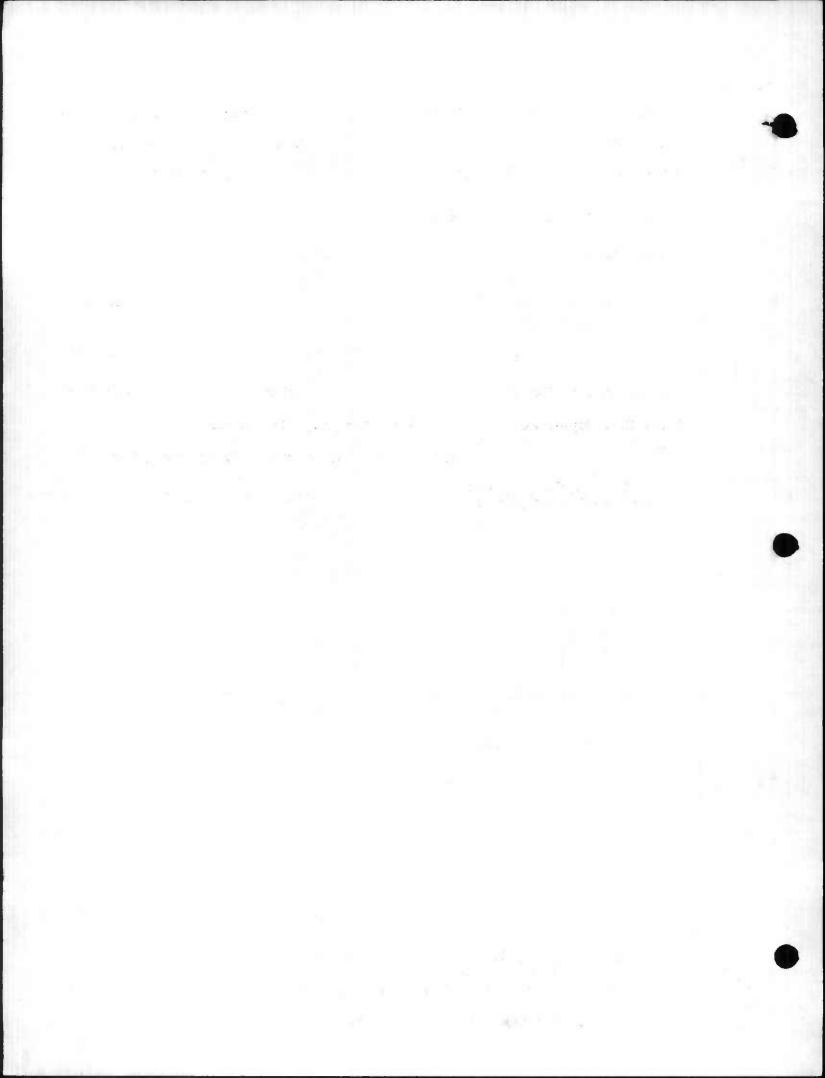
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State of Maryland / Department of Health and Mental Hygiene Q

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£.,	Physici /Medi		Virginia	Chaney	Raff				May 2	2, 1998		5:45 pm
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-			2450 Chaney Ro		ge (In yrs. last t	uirthriau)	If Under 1 Year	Dunkirk If Under 24 Hr			lvert	
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	show		10a. Stete 10b. County		10c. City, To		cation				100	d. Inside City Limits
	e Ma	ctor	MD Calver	τ	Dunki	rĸ						1 ☐ Yes 2 ☑ No
	23a or 29	Funeral Director	10e. Street end Number 2450 Chaney Roa	ıd			10f. Zlp Code 20	0754		10g. Citizen of V	Vhet Countr ISA	y?
21215-0020	filed within 72 hours after deeth with the Marylend Hyglene. ther than "naturel", or itema 23a or 28a-f show ont, the Medical Examiner must be notified at	by	11. Meritel Stetus 1 □ Never Merried 2 □ Merried 3 □ Widowed 4 ❤ Bivorced	12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes:			Wes Decedent of f Yes, specify Cut 1 ☐ Yes 2 ☐ No		Specify Yes or No irto Rican, etc.)		e - America ck, White, et : Whit	tc.
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Maryland	s 1 and 2 should be filed f Heelth and Mental Hyg tem 27 is marked other other traumatic event,	To Be	Thomas Morris					Myrtle	J. 11 21, 11 11 11 11 11 11 11 11 11 11 11 11 1		McCan	less
ary	should Man	Ĕ	19e. Informent's Name/Reletionship		15	b. Mailir	ng Address (Stree		Rural Route Numb			
			Leila O.W. Boyer	/daug.	1	392	Martz Ro	d., Harr	isonburg	, VA 22	2802	
Baltimore,			20e. Method of Disposition 1 Buriei 2 Cremetion 3 4 Donetion 5 Other (Spe		20b. Piece cemet All S	of Dispo eny, cren Saint	sition (Neme of natory or other piecs Epis.	Church	Dete 5-27-98	20c. Location - Sunder		
alti	permit. Pege Depertment of Important: If any injury or once.	Ì	21. Signature of Funesal Service Lie	ensee	P	22	. Name end Addr	ess of Fecility				
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	Physician /Medical		1- 1- 1	1 .		٠					(Onset and Death
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	To th To th comp	X	29b. Signeture end title of certifier		A		29c. Licen	se number		29d. Dete signed	d (Month, D	ay, Year)
			Afor	ala un	7		D45	385		5/23	198	
	15		30. Neme and address of person with	completed cause of d	(item 23e	(Type,	Print)				1	
	15		10845 Tow	n Center	BIVD	# 3	103, DU	nKIVK	MOdo	754		
	Sta Registr	_	31. Dete filed (Month, Day, Year)		er's Signeture							



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				State of Mary		Certificate of		vientai my	Reg. No.	8	7375
	Physic /Medi		Decedent's Name (First, Middle, Local ROBERT CORLE		PENCE S	SR		2. Dete of De Month MAY	Dey 23	Year 1998	3. Time of Deeth 11:36 PM
,	Exami		4e. Fecility Neme (If not institution, gi	ve street end number)			4b. City, Town, or L	ocation of Dee	th 4c. County	of Deeth	
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	Funeral			ATT NOTE -	yrs. lest birth	Months Days	if Under 24 Hrs. Hours Min.	/Adonth D	rth av. Year)	9. Birthple	ce (Stete or Foreign
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	sho	ų.	Toe. State Too. County	100	c. City, Town	or Location				100	d. Inside City Limits
	M of M	Director	Maryland Prince C	George's (Capitol	l Heights					1 GYes 2 □ No
	ith to 20	Dire	10e. Street end Number			10f. Zip Code			10g. Citizen of \		y?
	death with the Maryland ms 23a or 28a-f show	rai	1516 Opus Avenue			20743			US	oA.	
Maryland 21215-0020	d 2 should be filed within 72 hours efter death with the Marylan Ih end Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Maritei Stetus 1 Never Married Merried 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes;	in U,S.	 Wes Decedent of In If Yes, specify Cub Yes 2 No 		pecify Yes or No Rican, etc.)	Specify	ca - Americar ck, White, et	c.
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<u>a</u>	ld be ked ked ic ev	ToB	Samual C. Spence	4			Nancy Ta	avlor S	pence		
ary	Should No	-	19e. Informent's Neme/Reletionship		19b. N	Meiting Address (Street			-	Stete. Zip C	ode)
	C = N L		Dorothy M. Spend	re (wife)		16 Opus Ave					
Baltimore,	- 4 5 5		20e. Method of Disposition		Ob. Plece of D	Disposition (Neme of		Dete	20c. Location -		n, Stete
5	00-		1 ☐ Buriai 2 🏋 Cremetion 3 ☐ 4 ☐ DonAtion 5 ☐ Other (Specia	Removei from Stete		cremetory or other pla plitan Crem		26_98	Alexand	iria.	V/2
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7	/Medical Examiner		tmmediate Cause (Finet disease or condition resulting in death)	. Sept	icen	ria rsequence of):					7 clays 3 weeks
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	vicien: The lay certificate has rector, page 2	50						10	Yes 2 No	101	Yes 2□ No
	ysician: is certifica director,	Be	25. Wes case referred to medical				26. Place of Deet	h (Check only			
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0	ath. r: After ne fune	atic	1 Neturei 5 Pending Investigation		r) Inju		Yes 2 □ No				
DIVISION	or Attending F efter death. I Director: After d in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not b	28e. Piece of injury - /	At home, ferm	, street, fectory, office		28f. Location (Street and Numb	er or Rural F	Poute Number,
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1	To the		29b. Signeture end title of certifier	. 56		29c. Licens	e number		29d. Date signed	d (Month, De	y, Year)
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			30. Name and address of person who	completed cause of death (ttem 23e) (Tu				May .	~ , I	7 76
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death Month Vaar STMMONS GALE CLEDITH MAY 22,1998 23:15 pm 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 66 Yrs. Months Days Hours Min. (Month, Day, Year) March 28, 1932 Prince Frederick Calvert 5. Social Sacurity Number Birthpiaca (Stata or Foraign Country) 1 GM 2□ F 236 44 7330 Usual Rasidanca of Dacadant 10b. County Calvert 10c. City, Town or Location 10d. Insida City Limits Owings 1 Yas 2 TNo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 630 Skinners Turn Road 20736 USA 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. I SYas 2 No If Yas, Giva Yaar or Datas: 1952–55 1 Navar Married 2 Marriad 1 ☐ Yas 2 € No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry College (1-4or 5+) Elamantary/Secondery (0-12) tree removal/trimming tree expert 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Meiden Surnema) John Simmons Esther Mae Garev 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Lotte G. Simmons/wife same as 10 above 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Buriel 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Southern Mem. Gardens 5-30-98 Dunkirk, MD 21. Signature of Funary Service James 1 22. Nama and Addrass of Facility Rausch Funeral Home, Owings, MD 23 Part f. Enter the disease, or complications that be used the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line Onsat and Death Immedieta Causa (Final a ASPIRATION PATUM ONE 1-2 DAY5 disaasa or condition resulting in daath) Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 1 No 3 Probably 4 Unknown CHRUNIC OSSTRUCTIVE PULMUNDED DISTAGE CURUNARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? ARTIFICY DISPARE, DIAGETES A ELLING 1 ☐ Yas 2 ☐ No ORGANIC BROW STONE 26. Placa of Daath (Check only ona)

Physician /Medical Examiner

the burial-transit

Completed by

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Certification: To

The law requires that the death certificate be executed

certificate

this funeral

After

s efter death.

To the Hospital within 24 hours or To the Funeral Completely filled

filled in by the

Box 68760.

P.O.

Records,

of Vital

Division

Hospital or Attending Physician:

Department of Important: If any Injury or

Physician

/Medicai

Examiner

Funerai

Director

"natural", or Items 23a or 28a-f show suical Example; must be notified at

Peges 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or Rema 23 may or other traumatic event, the Medical Example many or other traumatic event, the Medical Example many or other traumatic event, the Medical Example many.

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altimore, Maryland

Director

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Sequentially list conditions, if eny, laading to immediata causa. Entar Underlying Causa (Diseasa or Injury that initiated events rasulting in daath) Last Physician/Medical

25. Was case refarred to medical examinar? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 27. Manney of Deeth 28b. Time of 28d. Dascribe how Injury occurred

28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 1 Naturel 5 Panding invastigation 1 Yas 2 No 2 Accidant

3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homloida

1 Certifying Physician: To the bast of my knowladga, deeth occurred et the time, dete and place, and dua to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, dete end place, and due to the causa(s) and mannar stated. 29a. Cartifiar Medical 29b. Signature and title of certifier 29c. Licansa numbar 29d. Data signed (Month, Day, Yaar)

D26358

an 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. John H. Weigel, M.D., Prince Frederick, MD 20678

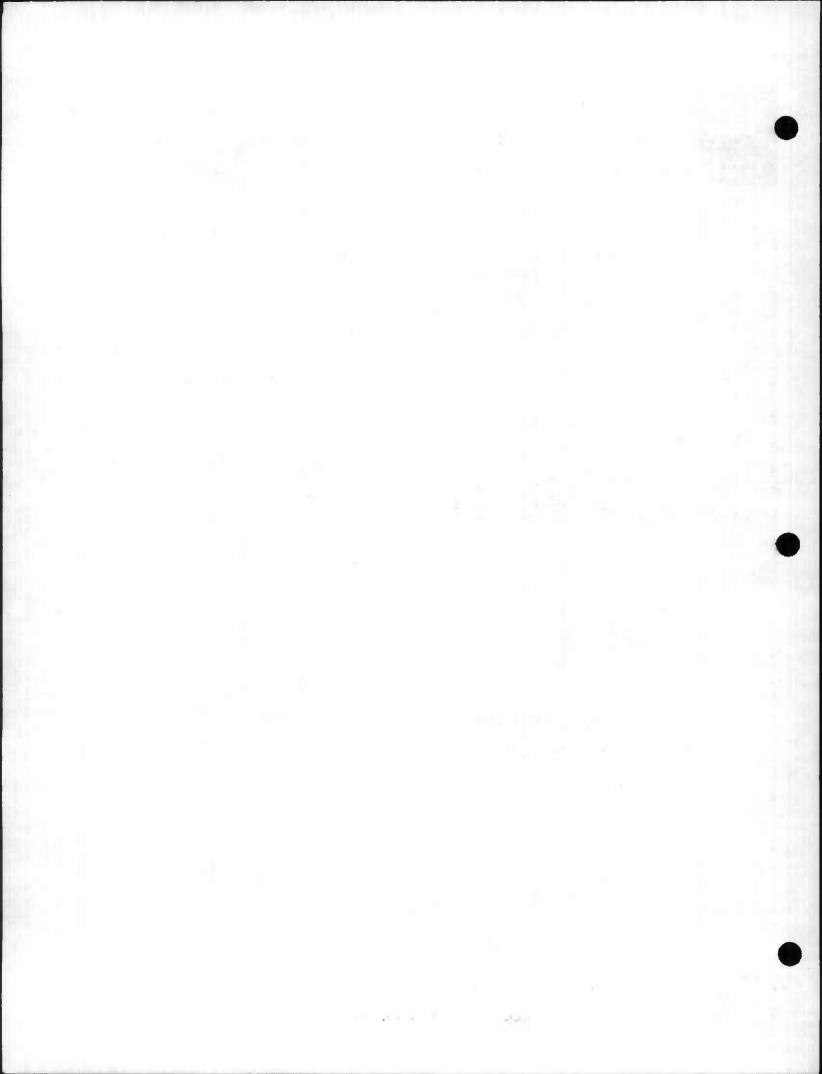
31. Dete and (Month, Day, Yeer)

MAY 27 1998

July Standard

10

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Yaar 1998 21, Jean Sykes May 3:40 a.m. Storrar /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min. May 22, 1919 5. Social Security Number 7. Aga (In yrs. last birthday) 78 6. Sex Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 F 172 16 1423 Yrs. PA Director Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Movical Examiner must be notified at Tracy's Landing Anne Arundel 1 Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 293 Fairhaven Road 20779 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Initury or other traumatic event, the Mexical Examines mantle once. Funeral 12. Was Decedent Ever In U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 LYes 2 No If Yas, Giva Yaar or Dates: 1943—45 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Supervisor US Gov't., Census 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meldan Sumama) Be Thomas Storrar Mariah Matthews 2 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. tntormant's Name/Relationship (Type, Print) Thornton S. Sykes/spouse same as 10 above 20b. Piace of Disposition (Name of comatary, cramatory or other place)
MD Veterans Cemetery 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramovai trom Stata 5-26-98 Cheltenham, MD 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funeral Sarylce Licensae 22. Nama and Address of Fecility Rausch Funeral Home, Owings, MD 20736 Adusch runeral home, Uwings of it. Enter the disease, or complications that seused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Acute myolardial Infaction /Medical Immedieta Causa (Final diseasa or condition rasulting in death) Examine Dua to (or as a consequence ot) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata cause. Enter Underlying Cause (Disease or Injury that initiated avants rasulting In daath) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consaquance of): signed by the a Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Juper tensin 1 Yes 2 No 3 Probably 4 Unknown by Diabela mellit should should 24a. Was an autopsy performed? 24b. Wara autopsy tindings available prior to completion of cause of daath? Completed s certificate has b 1 Yas 1 ☐ Yas 2 ☐ No al or Attending Physician: T s after death. Il Director: After this certificat od in by the funeral director, po Be 25. Was casa ratarred to medical axaminer? 26. Placa of Death (Check only ona) Hospitai: Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 DER/Outpatient 3 ☐ DOA 28a. Data ot Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending Invastigation 1 Neturai 1 Yas 2 No 2 Accidant 6 Could not be datamined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Piaca of Injury - At homa, tarm, straat, factory, offica building, atc. (Specify) 4 Homicide 29a. Cartifiar Medical 1 Certifying Physicien: To tha bast of my knowledge, deeth occurred at tha tima, date and piece, and due to the causa(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titia ot certifier 29d. Data signed (Month, Day, Year)) levba IVA 30. Nama and address of person who completed causa of death (Item 23e) (Type, Print) 134 Ovensville Rd, West River, My Wayne D. Gerbaum

State

Registrar

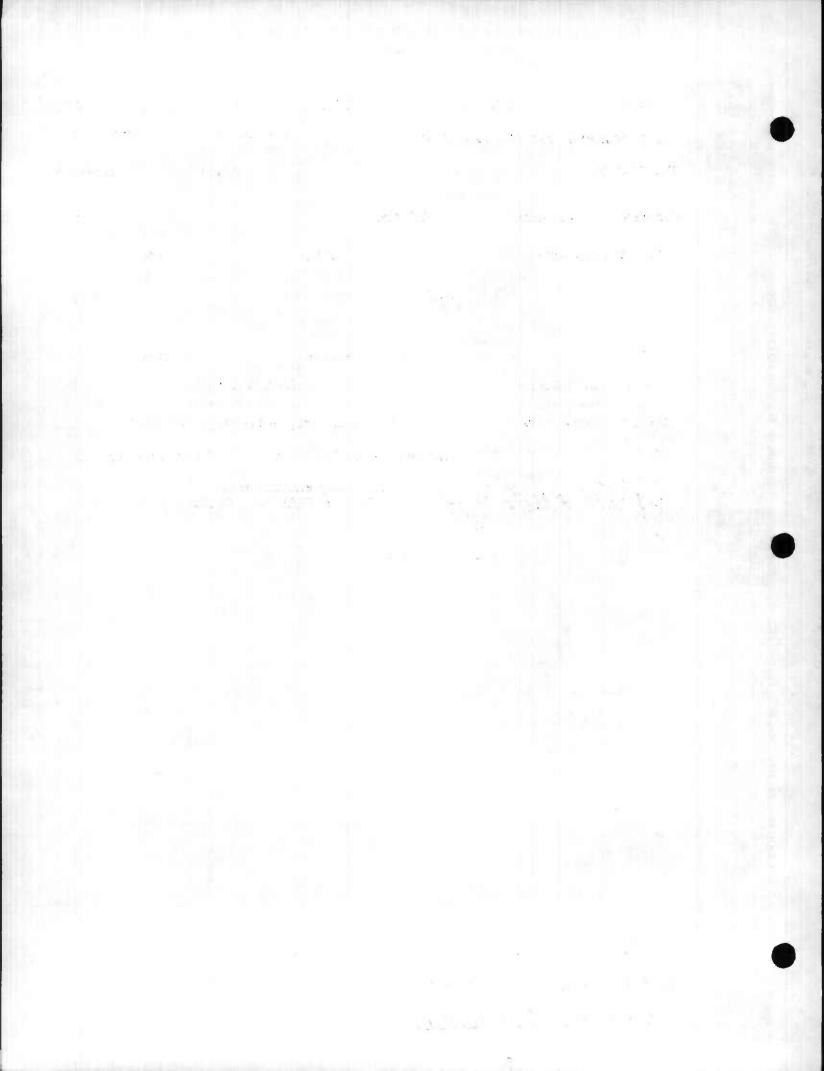
31. Data filed (Month, Day, Year)

32. Registrar's Signeture

Da John Davidson Rondall

218-24-5628

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Tima of Deeth 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 998 MAY Lois J. Shockley 0610 4s Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Dasth 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Months 1 ☐ M 2 🖾 F Yrs. 50 218-48-8560 28, 1947 Maryland Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXWas 2 □ No Wicomico Fruitland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 501 Shelton Avenue 21826 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: White 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Dacedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada completed) Elamantary/Sacondary (0-12) Collega (1-4or 5+) Garment Company Seamstress 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumema) Oscar Carl Long Ethel Juanita Mooney 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Sherri Workman/Daughter 510 Priscilla Street Salisbury, MD 21804 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 5-19-98 Melsons Cemetery Delmar, Maryland 21. Signature of Funaral Sarvica Licansee 22. Nama and Addrass of Facility Short Funeral Home, Inc. lean 13 E. Grove Street Delmar.
Do not antar tha moda of dylng, such as cardiac or raspiratory arrast Delmar, DE 19940 23a. Part 1. Entar the disease, or complications that caused in shock, or heart failura. List only one cause on each line. Approximete Intarval Batween Onsat and Death

Physician /Medical Examiner

Examiner

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Certification: To

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Important: If it any injury or o

Physician

/Medical

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Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan nent of Health and Mental Hyglene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examinar must be not taken.

Department of Health

Sockley 218-48-8560

The law requires that the death certificete be executed physician and the burial-transit Physician/Medical attending phy signed by the a d be deteched f Py should Completed

s certificate has b i or Attending Physician: after death. Director: After this certifica director funeral the To the Hospital or Atter within 24 hours after det To the Funeral Director completely filled in by th

Division of Vital Records, P.O. Box 68760.

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avents rasulting in daath) Last

25. Wes casa refarred to medical axaminar?

5 Panding

Invastigation

6 Could not be datarmined

1 Yas 2 No

27. Mannar of Deeth

Natural

2 Accidant

3 ☐ Suicida

4 Homicida

Immadiata Causa (Final disaasa or condition resulting in daath)

12

Due to (or es e consequence of): Dua to (or as a consaquanca of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

es a consequence

24a. Was an autopsy

24b. Wara autopsy findings available prior to completion of cause

3 Probably 4 Unknown

1 Yas 2 No

1 ☐ Yas 2 ☐ No

26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Tima of 28e. Date of Injury (Month, Dey Year) 1 Yas 2 No

28a. Placa of Injury - At homa, farm, straat, fectory, offica building, atc. (Specify)

28f. Location (Streat and Number or Rural Roufa Number, City or Town, Stata)

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Ell Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licensa number

20507

23b. Did tobacco use contribute to the cause of death?

2 No

30. Nama and add as

of person who complated cause of deeth (Item 23a) (Type, Print)

ORACSO 145 E. CARRULL St., SALISBURY JOS-CAN N. G.
31. Data filad (Month, Day, Year)

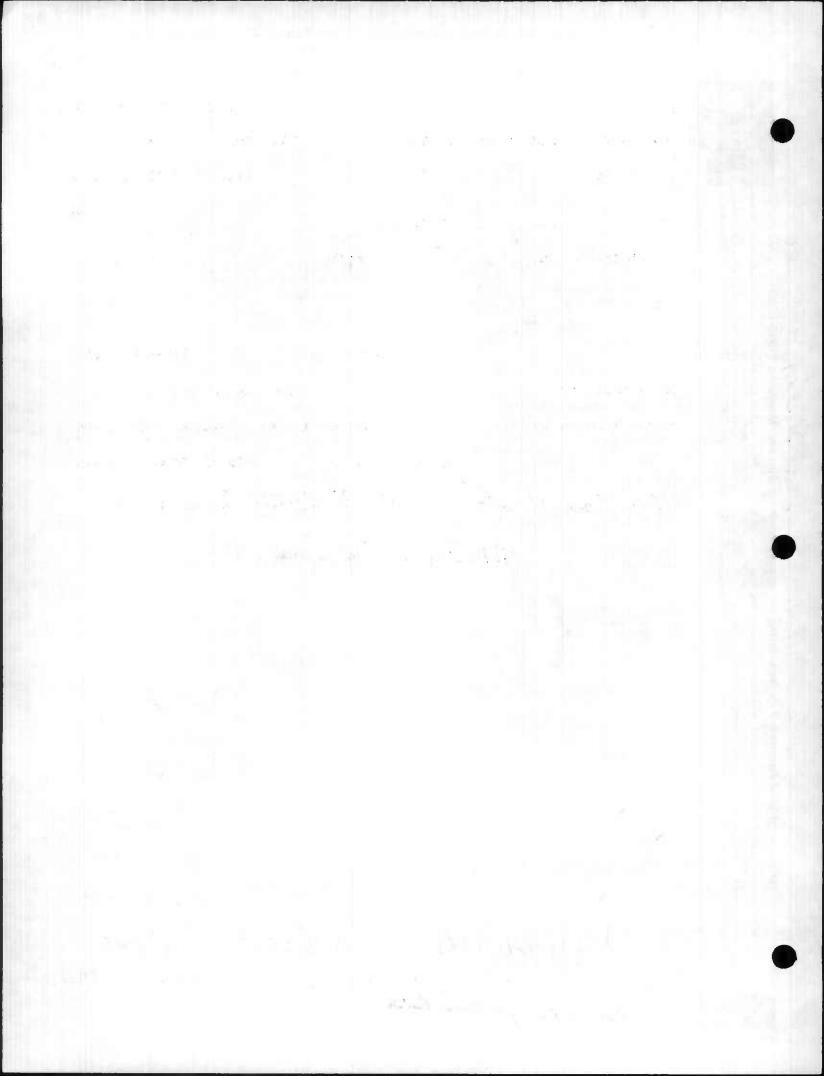
MAY 181998

32. Registrar's Signeture

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State

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 998 Month **Physician** Lorena Stafford Wood May 25, 0620 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert County Nursing Home 7. Age (In yrs. last birthday) | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplaca (State or Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 1. Dec 24 Hrs. | 5. Social Security Number 9. Birthplaca (State or Foreign **Funeral** 1□M 2□F Director 219 48 0611 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Prince Frederick Maryland Calvert 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20678 5594 Hallowing Point Road death 12. Was Decedant Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. of fled within 72 hours after if Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 white 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 □Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) own home 8 housewife Mother's Name (First, Middle, Maiden Sumame)
ebecca Tucker 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if item 27 is marked oth any Injury or other traumatic event pages. Be Rebecca Charles Stafford 19b. Malling Address (Street and Number or Rural Route Number, City or Town Prici 70 Compression FRederia 19a. informant's Name/Relationship (Type, Print) E.Dwan Hardesty- granddaughter 396 South Shorre Ter. #5 Maryland 20678 20e. Method of Disposition
1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stata Asbury Cemetery May 27 1998Barstow Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4405 Broomes Is. Rd. Port Republic 2067 20 23a. Pert1. Enter the disease, or compilications that caused the death. Do not entar the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Carcinomatosis of uncetain Primary /Medical Immediate Cause (Final disaese or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner ettending physician and Hor use as the burief-transit certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disesse or Injury that initiated events Due to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): rasulting in death) Lasi ed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. by page 2 should Completed 24b. Were sutopsy findings available prior to 24a. Was sn sutopsy performed? completion of cause of death? certificate hes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 2 After this 28c. Injury at Work? 27. Manner of Desth 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation Injury → Naturai spital or Attendin hours efter death. heral Director: Aft / filled in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde To the Hospital within 24 hours or To the Funeral Completely filled Cartifying Physicisn: To the best of my knowledge, death occurred at the time, dete and place, and due to the csuse(s) and manner ss stated.

2 Medical Examiner: On the bests of axamination snd/or investigation, in my opinion, death occurred at the time, data and place, snd due to the cause(s)

State Registrar

Medical

29a. Certifier

29b. Signature and titla of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed caus

MAY 26

and manner stated.

death (Item 23a) (Type, Print)

Jonathan Lowenthal, M.D. 120 Hospital Rd. Suite 32. Registres Signature

29c. License number

29d. Date eigned (Month, Day, Year)

Maryland 20678 e 200Prince Frederick

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				olate of ivia	arylanu /	Certificate of			9 8 g. No.	7381
	Physici /Media		Decedent's Neme (First, Middle, Last) MILDRED	COX		WARD		2. Date of Death Month MAY 17,	Day Yeer 1998	3. Time of Deeth 21:00
	Examir		4e. Fecility Name (If not institution, giva str	eet and numbar)			4b. City, Town, or Lo		4c. County of Deeth	
			Calvert Memorial Ho				Prince Fr		Calvert	
	Funeral Director		5. Social Security Number 212 74 7939 6. Sex		(In yrs. lest b	irthday) if Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey.) July 27	1905 Mar	place (Stete or Foreign intry) yland
	/land		10a. Stete 10b. County		10c. City, Tov	vn or Location				10d. Inside City Limits
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	th with the 23e or 28 set be not	ai Director	10e. Street end Number 6522 Lower Marlbord	Road		10f. Zip Code 20736	5	10	g. Citizen of Whet Cou USA	intry?
020	n 72 hours after death with the Maryland "neturel", or items 23e or 28e-f show police Examinet must be notilied at	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:		13. Wes Decedant of H If Yes, specify Cub. 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Maxican, Puerto Specify:	ecify Yas or No- Rican, atc.)	14. Race - Amer Bleck, White Specify: Wh	
21215-0020	C * B	Completed	15. Decedent's Educat (Specify only highest grade of Elementery/Secondary (0-12)		+)	e. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work d)	ing	6b. Kind of Businass/li	ndustry
D	Hygin Hygin	CO	17. Fether's Neme (First, Middle, Last)	2	2	school teache	18. Mother's Name			
lan	should be id Mantal marked o	To Be	James Mervin Cox				Maude El	Lizabeth	Lyons	
Maryland	s m s		19e. Informent's Neme/Reletionship (Type	Print)		b. Meiling Address (Street				ip Code)
	C = 0 F		Dallas S. Ward /	son	_	502 Lower Ma	rlboro Ro			
Baltimore,			20e. Method of Disposition 1 № Buriel 2 □ Cremetion 3 □ Ren 4 □ Donetion 5 □ Other (Specify)	ovel from Stete	cemete	of Disposition (Name of ery, cremetory or other ple Marlboro Ce			wings, MD	own, Stete
Ball	permit. Pegas Department of Important: If it any injury or once.		21. Signature of Funerel Service Licensee	Kom		22. Name end Addre		e, P.A.,	Owings, N	ID 20736
2	Physician /Medical Examiner	er	resulting in dealin)	CVA		not enter the mode of dylr consequence of):	ng, such es cardiac d	or raspiratory arres	it,	Approximate intervel Between Onset and Death
Box 68760,	leath cartificate be executed attanding physician and if for use as the bunal-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate	acute	- M	consequence of):	of m	ardioi		
	death car e attandin ed for usa	sicia	Pert II. Other significant conditions contrib	uting to death bu	t not resulting	In the underlying cause dis	en in Pert I	23b. Did tob	acco use centribute	to the cause of death?
P.0	that that ed by th datache	by Physician/M				g.,		1 🗆 Yas		obably 4 Unknown
Records,	s been s	Completed b						24e. Wes en performe	ed?	Vere eutopsy findings vailabla prior to ompletion of cause if deeth?
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or Vital		o Be	25. Was case referred to mode at exeminer? 1 Yes 2 Yes	pital:		Oth	26. Plece of Death er:			
on of	Attanding Physic death.	tion: To		I I npatier 28e. Date of Injun (Month, Dey		Time of fnjury 28c. Injur	4 U Nursing Ho	me 5 Li Residen 28d. Describe how	ce 6 ☐Other (Spec rinjury occurred	f(y)
=	or Attending P safer death. I Director: Affar to in by the funeration of the function of the funeration of the funeration of the function Certification:	2 Suiside 6 Could not be	28e. Plece of Inju building, etc.	ry - At home, for (Specify)	arm, street, factory, office		28f. Location (Stre City or Town,	et end Number or Rui Stete)	ral Routa Number,	
	To the Heapital or Attending Ph within 24 hours after death. To the Funeral Director. After th complately filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physical Examiner	en: To the best of On the basis of end menner stet	exeminetion er	e, deeth occurred et the tir nd/or Investigetion, in my o	ne, dete end plece, opinion, death occurr	end due to the ceu ed et the time, det	se(s) end menner as e and plece, and due	steted. to the ceuse(s)
	To the To the comp	Me	29b. Signature and title of certifier	Smi	dan	29c. Licens D17		290	1. Deta signed (Month)	, Day, Yaer)
		-	30. Neme and eddress of person who comp	leted cause of de	eth (Item 23a)				1.01.0	
	12		KIOUMARCE YAZDANI,	M.D., H	UNTING	IOWN, MD 20	639			
	Sta Registra		31. Dete filed (Month, Day, Yeer) MAY 22 1	32. Registra	s Signeture	korkadall				

Service of the servic

LLIS				State of		C	Certifica	te of	Death			Reg. No.	0	1/	302
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/Me	dical	40	John Henry a Facility Name (If not institution, g						4b. City, Tow		AY on of Death		998 ty of Death		45A.M.
Exan	niner		00 CLUBHOUSE	ivə streət ərici riuri	Der)				PRINCE			CALVE		,	
Funer	al				7. Age (In yrs	i. lest birtho		er 1 Year	If Under 2	4 Hrs. 8.	Date of Bir (Month, Da	th	9. Birth	hplace (S	tete or Foreign
Directe		U	361 24 1674 Usual Residence of Decedent	1 ∑ M 2□ F	67	Yrs		s Deys	Hours		an 4			linc	
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death with the	ō	10	De. Street and Number	Drive				ip Code 2065	57			10g. Citizen of United			5
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2 should by and Menta ie marked eumatic ev	-	-	19e. Informant's Name/Relationship	(Type, Print)		19b. N	Meiling Addre	ss (Street	t end Number	or Rural R	oute Numb	er, City or Tow	n, Stete, Z	(ip Code)	
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Division of Tothe Hospital or Attending P within 24 hours after death.
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29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certilier 29c. License number MAY 15,1998

30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

Margarita Korell M.D.
31. Date liled (Month, Dey, Yeer)
MAY 21

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

32. Registrar's Signature

July Standard Randall

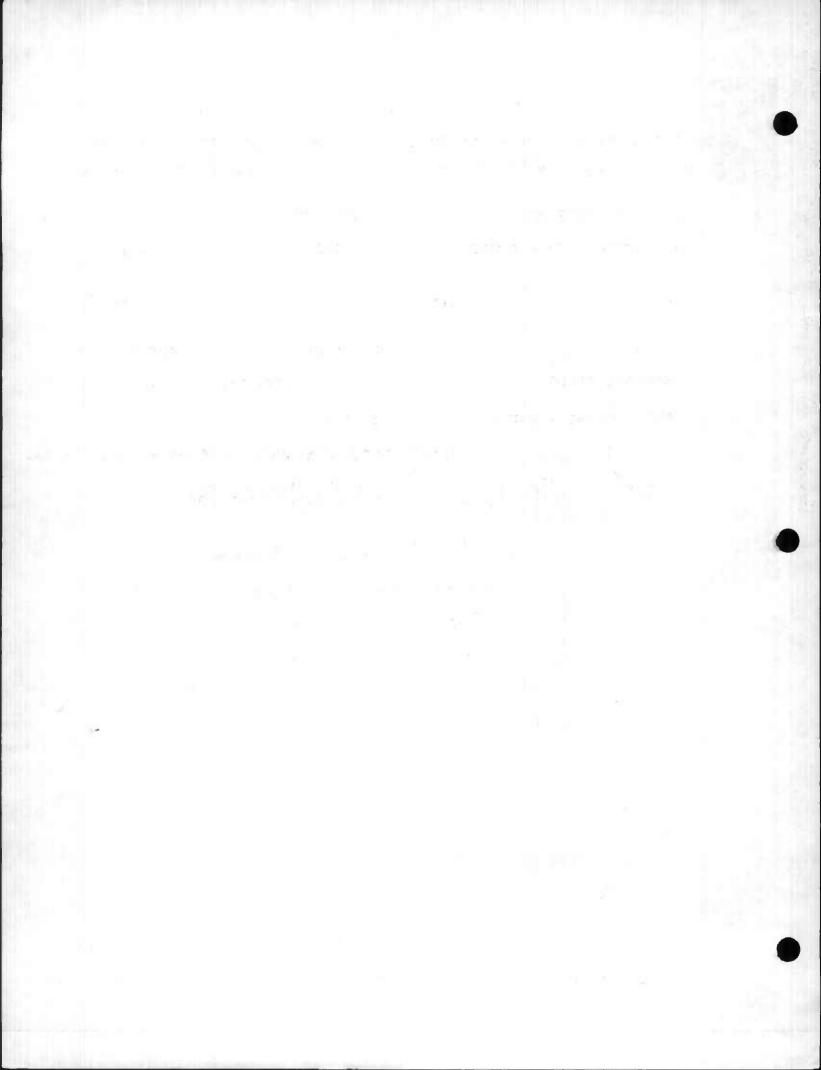
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** APPLEBY MILDRED 18:05 1998 JUNE 2 · /Medical GOO NORTH WOLFE 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner BALTIMORE BALTIMORE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 2128 7

lest birthday) If Under 1 Yeer

Nonths Deys 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Hours 1 M 2 KF 217-26-5126 Usuel Residence of Decedent une 26 **Director** the Maryland 10d. Inaide City Limits 10b. County 10c. City. Town or Location 10a Stete 7 is marked other than "natural", or frame 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Makuland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code with 21286 1522 Funeral death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, One Race - American Indien, Bleck, White, etc. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exemples. 1 ☐ Never Merried 2 ☑ Merried 1□ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) dyks 18. Mother's Nem (First, Middle, Meiden Sumarge) 17. Fether's Name (First, Middle, Last) Be OL 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Jakuland OWSON WOXPUR July 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriei 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signeture of Funeral Service Licenses Evans 23a. Pert f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical OF THE LUNG ADENOCARCINOM A YEARC Physician/Medical Examin Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Due to (or es e consequence of): resulting in death) Lest 8 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No á 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed inector, page 2 s 1 TYes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Death (Check only one) Be Hospitel: 1 ဩnpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 100 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 27. Menner of Death Certification: Affar or Attending 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) after 4 Homicide Funeral edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 24

State Registrar

DIGLISIC 31. Date filed (Month, Day, Year) JUN 0 5 1998

29b. Signeture end title of certifier

UHC

GORDANA JOHNS HOPKINS HOSPITAL, GOO NORTH WOLFESTERET 32. Registrar's Signetuce. who Daydoon Mandale

1000aug

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

mD

29c. License number

29d. Date signed (Month, Dey, Year)

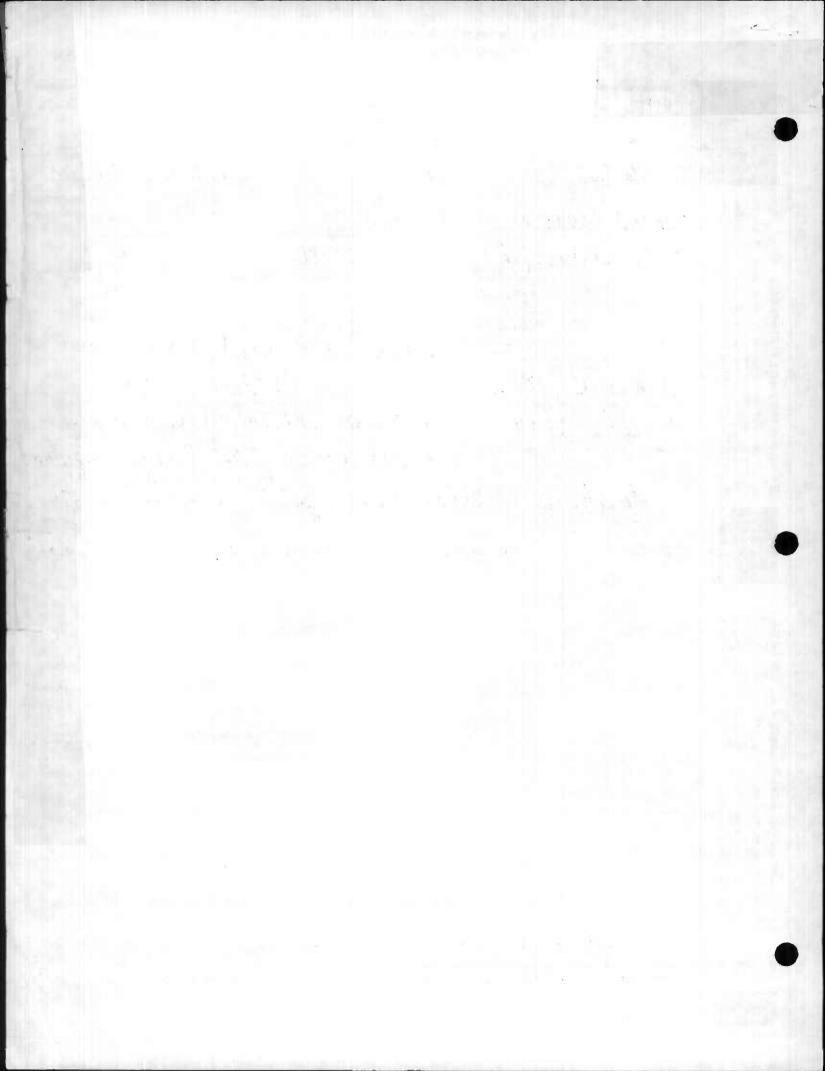
FUNE 2, 1998

BALTIMORE MD

To the within 2 2

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death Month 3 2 1998 10.10 AM **Physician** THOMAS E. ABEL JUNE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital n/a Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 100 M 2 F Months 78 Yrs. 237-26-2539 SC Nov. 14, 1919 Usuai Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 10 yes 2 □ No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3709 W. Franklin St. 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify: Black by **X**O€Vidowed 4 □ Divorced Year or Detes: WWII 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator 4th Vandenburg Food 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fether's Name (First, Middla, Last) Lawrence Abell Amanda Adams 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Amina Johnson/granddaughter 3829 Callaway Ave. Balto., MD 21215 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurlai 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) New Pilgrim Cemetery 6/8 Simsonville, SC 21. Signature of Funaral Sarvice Ligensee James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 23a. Pant Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heer feilure. List only one cause on eech line. Approximate Intervet Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRACRANIAL HEAMORRHAGE 3 DAYS Due to (or as e consequence of) Examine Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DEEP VENOUS THROMBOSIS 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Neturel 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28a. Piaca of Injury - At home, farm, straat, factory, office bullding, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

P-10883

29d. Data signed (Month, Day, Year)

JUNE 379 1998

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physician and s the burial-transit the death certificete be executed

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.
Other than "natural", or flems 23a or 28s-f show ent, fire Modelland all man home must be notified all

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If tem 27 Is marked other any Injury or other traumatic event.

Physician

/Medicai

Examiner

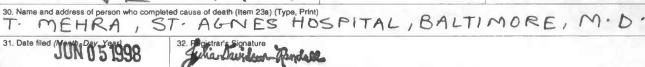
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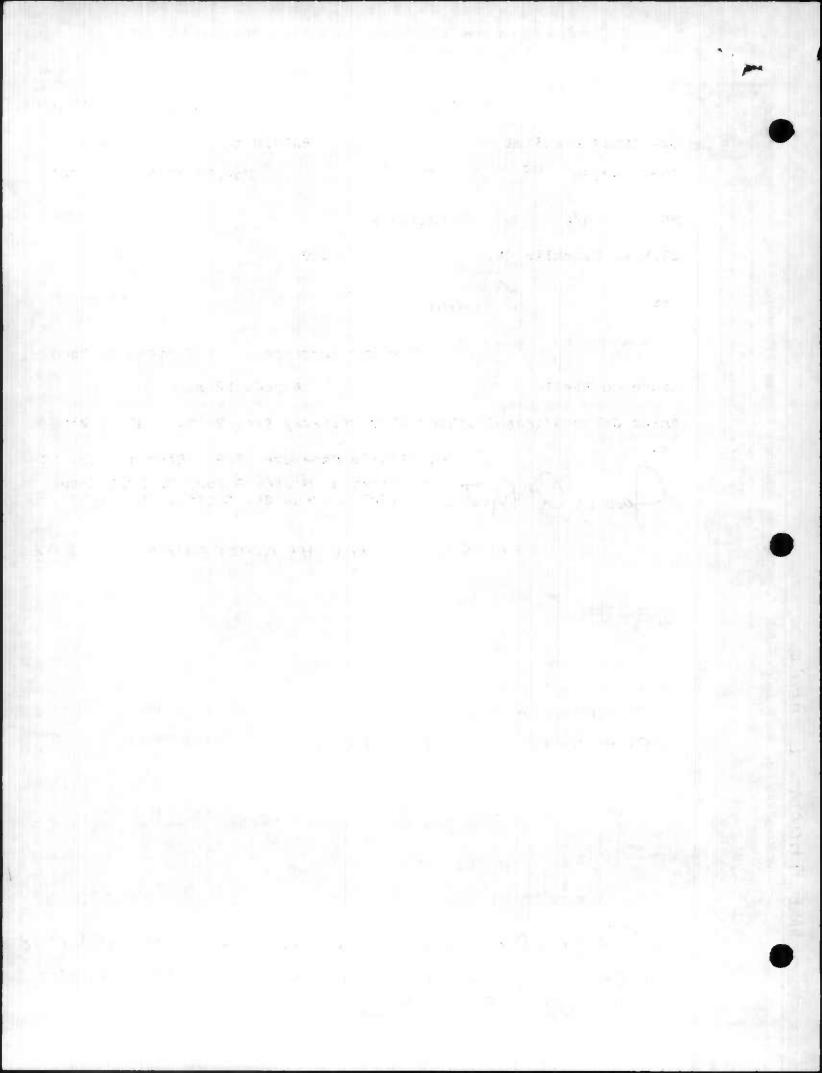
29a. Certifian

(Check only one)

29b. Signature and the of cartifier



m MEWAS M.D.

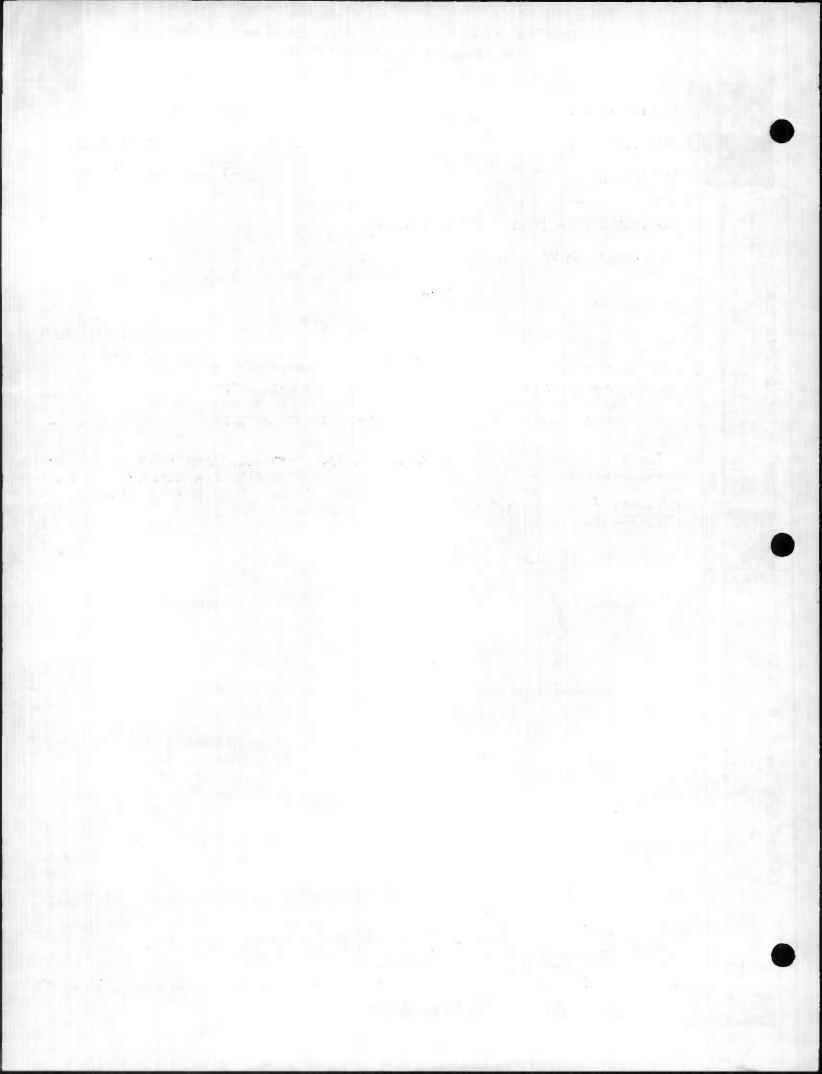


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Yee **Physician** ANDREWS PARKER 1998 3:00AM JUNE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not Institution, give street end number) Examiner 8262 AHEARN DRIVE MILLERSVILLE ANNE ARUNDEL 8. Dete of Birth (Month, Day, Year)
MAY 24, 19 If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In vrs. last birthdev) Birthplece (State or Foreign Country) **Funeral** Months 1 M 2 □ F Devs 65 MARYLAND Director 219-30-4254 Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itsms 23s or 28s-f show traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 1 No Director MARYLAND ANNE ARUNDEL MILLERSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8262 AHEARN DRIVE 21108 Funeral U.S.A. death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Maritel Stetus permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Wedest Exempted Bleck, White, etc. 1 ⊠ Yes 2 □ No 1952 --If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ▼ No Baltimore, Maryland 21215-0020 Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorcad Yeer or Detes: 1961 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ANNE ARUNDEL COUNTY Elementery/Secondery (0-12) College (1-4or 5+) DIRECTOR PUBLIC WORKS 18 Mother's Name (First Middle Melden Sumeme) 17. Fether's Neme (First, Middle, Last) CHARLES FRANCIS ANDREWS BERTHA DISNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 8262 AHEARN DRIVE MILLERSVILLE, MARYLAND 21108 MARION FRANCES ANDREWS-WIFE 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND VETERANS CEMETERY6/5/98 CROWNSVILLE, MARYLAND 21 Signeture of Funeral Service Licensee 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE., S.W. GLEN BURNIE, MARYLAND 21061 -ichael This is the caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, cardinal each line. 23a. Pert1. Enter the diseese, or complication shock, or heert failure. List only one car Approximete Intervel Between Onset and Deeth **Physician** /Medical fmmediate Cause (Final " necome diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last pue Due to (or es e consequença of): Physician/Medical Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evellable prior to 24a. Was en autopsy performed? Completed completion of cause of deeth? hes page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: I or Attanding F efter death. Diractor: After After 1 Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funeral C 29a. Certifier Medicai 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, and due to the cause(s) and member stated. To the Vithin 2 29b. Signeture end tille of certifier 29c. License number 29d. Det# signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) STANLEY P. M.D. 900 BESTGATE ROAD SLITE 300 ANNAPOLIS, MD 21401 WATKINS, Jr. 32. Registrer's Signature 31. Dete filed (Month, Dey, Year)

State Registrar

JUN 0 5 1998



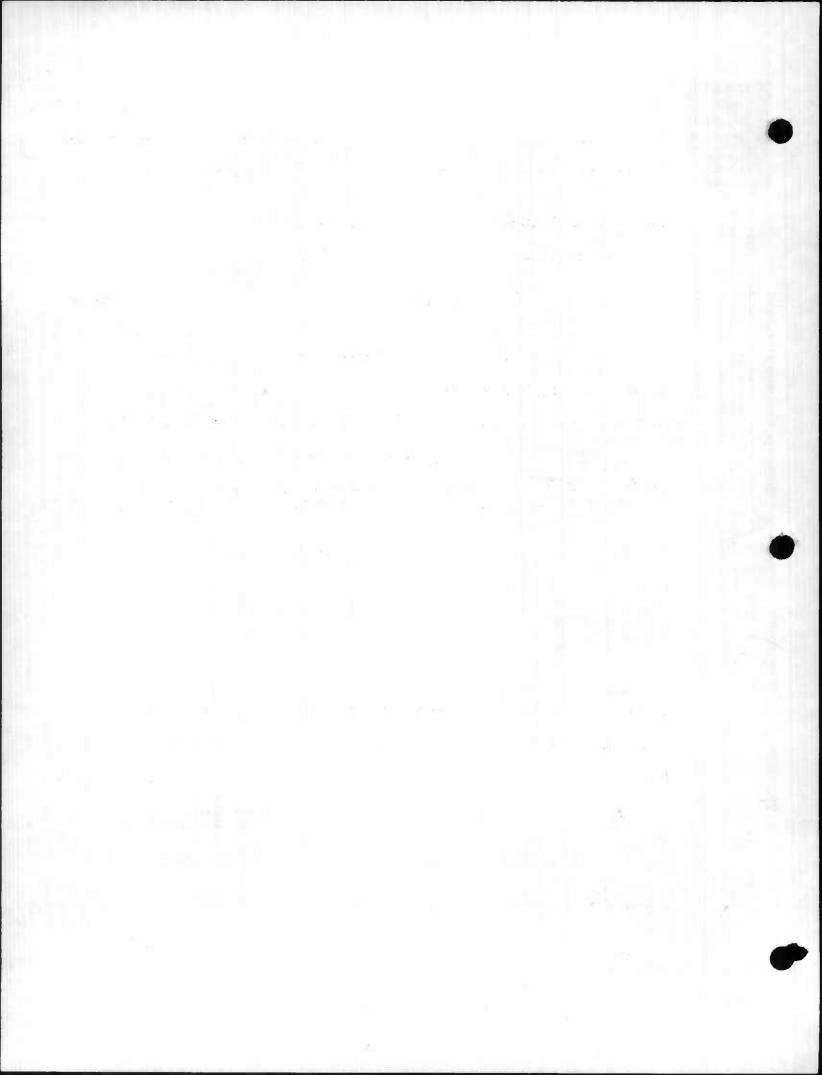
Please Type or Print in Biack Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 3:30 AM William Aubrey Blankinship 1998 June /Medical 4b, City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner 407 Dobbins Lane Pasadena Anne Arundel If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**∑** M 2□ F Deys 440-18-0237 Yrs. Virginia 77 AUG 18, 1920 Director Usuel Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street end Number 10f. Zip Code 10a, Citizen of Whet Country? 407 Dobbins Lane 21122 USA Department of Health and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1∑ Yes 2□ No
If Yes, Give
Yeer or Detes:1944-1954 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White P 3 ☐ Widowed 4 🏋 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) National Security Elementery/Secondary (0-12) College (1-4or 5+) Agency Mathematician 5+ 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Robert Aubrey Blankinship Lela M. Riddle 19e. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Richard A. Blankinship/Son 407 Dobbins Lane Pasadena, MD 21122 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Buriel 2X Cremetion 3 ☐ Removel from State 6 Metro Crematory, Inc. 06/04/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Puneral Service Liga 22. Name end Address of Fecility
Cremation Society of MD, Inc. din Edward A. Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications thei ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Congestive Heart Failure Examiner Doe to (or es a consequence of) Examiner Circhosis Due to (or es a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Physician/Medical that initieted events resulting in deeth) Lest Due to (or es e consequence of). 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. Division of Vital Records, P.O. Thtracranial bemorrhage. 1 Yes 2 No 3 Probably 4 Unknown Atrial fibrillation, þ 24b. Were autopsy findings evelleble prior to completion of ceuse of death? 24a. Was en eutopsy performed? Completed , Liver hematoma CoaquiopaThy Anemia 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Be Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA min 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: Neturel 5 Pending 1 Tes 2 No Investigation 2 Accident after death Director: 7 6 Could not be determined 3 Sulcide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours of To the Funeral C 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 6/4/98 D29209 Candace Chardle-MD 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)
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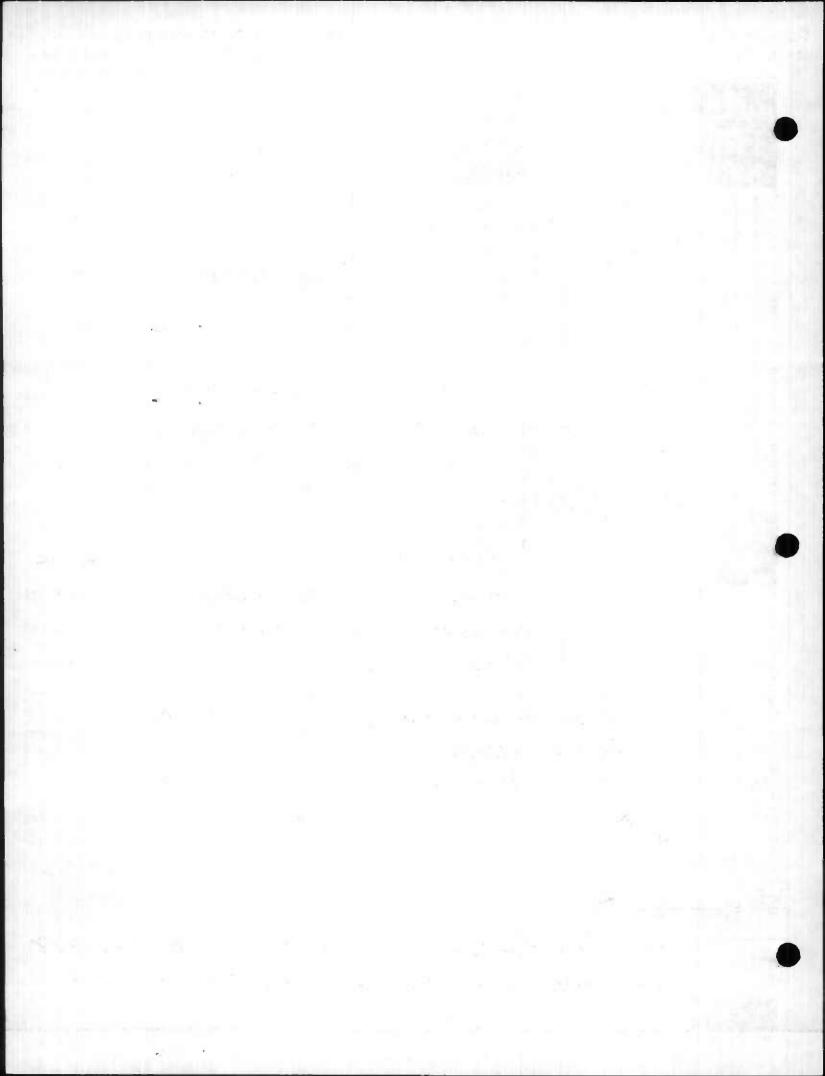
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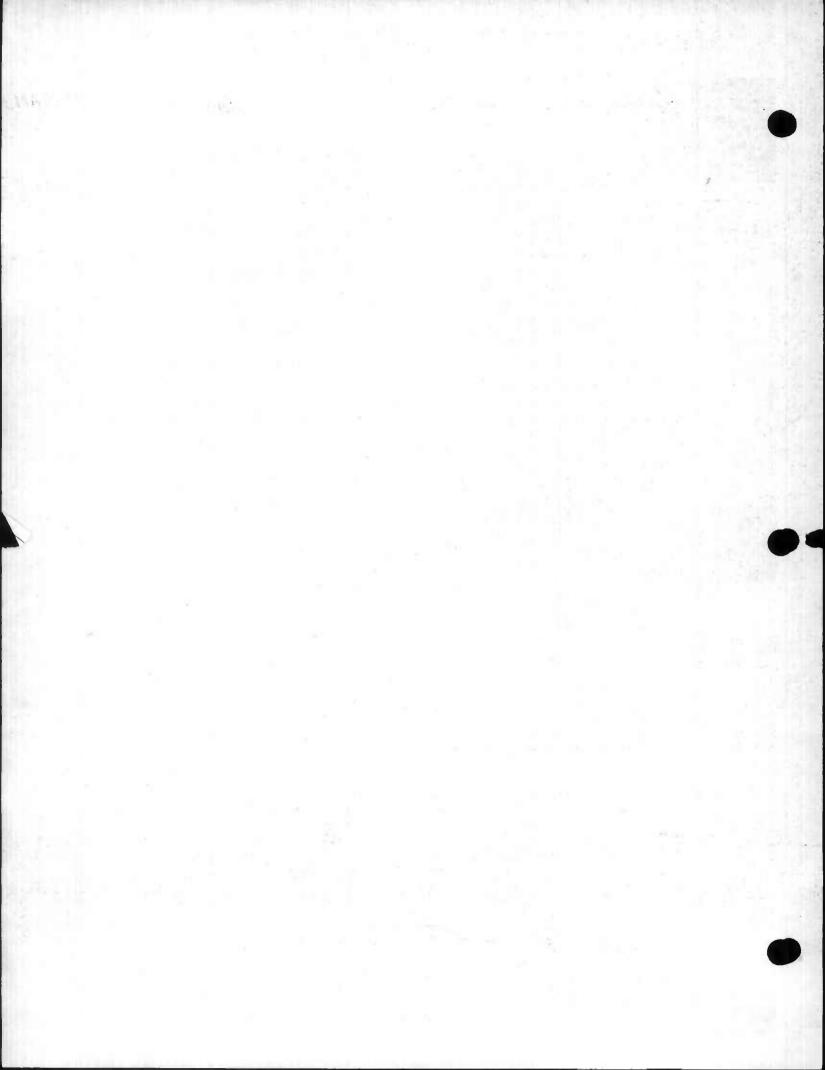
State of Maryland / Department of Health and Mental Hygiene 🔾 🔉

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	/Medi Examir		4a. Facility Name (If not institution, give						4b. City, Town, or I		4c. County	of Death	4.13 p.m.
П			Avalon Manor Nur	sing Home					Hagersto	wn .	Washi	noton	
Н	Funeral		5. Social Security Number 6. 5	Sex 7. Ag	e (In yrs. le	ast birth		1 Yaar	if Undar 24 Hrs.				ace (State or Foreign
N/A	Director		579 18 8154 Usual Rasidence of Decedant	1□M 2XIF	80	Υ	Months	Days	Hours Min.	April 13,	1918	Mary]	
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21215-0020	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Haaith end Mental Hygiene. Important: if item 27 is marked other than "nature!, or items 23a or 28a-f show any folury or other traumatic event, the Medical Examine must be incitited at once.	by Funeral Director	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Datas:		o.	If Yas, spe		dispanto Origin? (S an, Maxican, Puert Specify:	o Rican, atc.)	Bia	w. White	atc.
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	To the Hospital or Attending Physician: The lew within 24 hours after death. To the Funeral Director: After this cartificate hes completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) Certifying Pr	nyalcian: To the best of minar: On the basis of end mannar sta	examineti	vledga, on end	daath occurred for investigation	at tha ti	ma, data and place opinion, death occu	, and due to the corred at the time, d	euse(s) end m ete end placa,	annar as st and due to	ated. tha cause(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 9:16 AM William Nelson Byram, Jr. 1998 May 31, 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Laurel Regional Hospital Laurel Prince George 8. Dete of Birth (Month, Dey, Year) Nov. 13, 19 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Deys M 2□ F Months Hours Min. 71 Yrs. 579-26-9014 1926 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Prince George Laure1 Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 USA 16300 Dorsett Road 12. Was Decedent Ever In U.S. Amned Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Married 1 Yes No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Security Guard Agency 11 Owner 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) William Nelson Byram, Sr. Nina Mae Homes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 16300 Dorsett Road, Laurel, Maryland 20707 Diane Byram/Wife 20b. Pleca of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXX Cremation 3 ☐ Removal from State Baltimore Washington Cr. 6/2/98 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Logisse 22. Name and Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 Clications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Death Immediate Cause (Finei disease or condition resulting in death) Due to (or as a consequenca of):

COMMANY MANDAY VISEASE

Due to (or as a consequenca of):

LYNEM TENGLIN Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the besis of exeminetion and/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and manner stated.

29c. License number

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ettending pl signed by the e been si is certificate hes director, page 2

Physician

/Medical

Examiner

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Physician/Medical

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Completed

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Certification: To

29e. Certifier

physician and the buriel-transit To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

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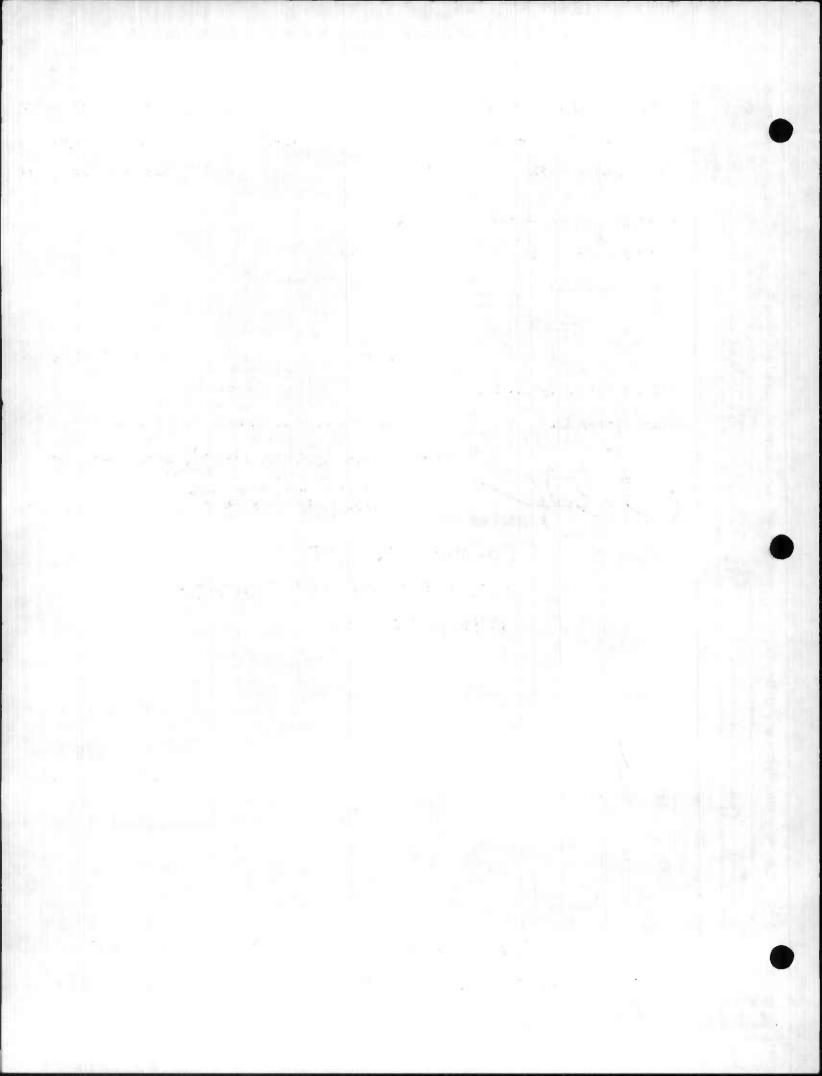
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31. Date filed (Month, Day, Yea.

29b. Signeture end title of cartifier

32. Registrer's Signeture whia Vavidson

29d, Dete signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** Month Joseph F. Biedlingmaier 30 3:50 A.M. May 1998 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 6303 Gallery Street Bowie Prince George's 5. Sociel Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months Min. XXM 2□F Hours Director 077 36 7509 52 Nov. 8, 1945 New York Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Health end Mentel Hygiene. nt: If Item 27 is marked other then "natural", or Itams 23a or 28a-f show 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner trans be notified at Director ★W Yes 2 No Maryland Prince George's 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 6303 Gallery Street Funeral 20720 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Bieck, White, etc. 1 Never Married Married 1₽ Yes 2□ No If Yes, Give Yeer or Dates: Vietnam Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No by Specify: White 3 Widowed 4 Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Owner Hardware/Retail 17. Fether's Neme (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) Be Joseph F. Biedlingmaier June E. Reif 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) wortant: If item 27 is n vinjury or other Jacqueline Biedlingmaier Wife 6303 Gallery Street Bowie Maryland 20720 20b. Plece of Disposition (Name of cematary, crematory or other plece)

June 2, 20c. Location - City or Town, Stete Date 98 h Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pege Department of Important: If any injury or once. Mt. Olivet Cemetery Washington D.C. 21. Signature of Funerel Servica Licansee 22. Neme end Address of Fecility Robert E. Evans Funeral Home, Inc. omplications that caused the death. Do not anter the mode of dying, such as cardiac or raspiretory arrast, only one cause on aach line. Approximata Intervel Between Onset end Death **Physiclan** /Medical Immediate Ceuse (Finel diseese or condition rasulting in death) week heumonia **Examiner** Due to (or es a consequence of): Examiner Metastatio lung concer year Sequentially list conditions, if any, leeding to immediata cause. Entar Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequança of): The law requires that the death certificety signed by the a Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause givan in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by this certificate has been singled director, page 2 should 24a. Wes en autopsy performed? 24b. Ware autopsy findings availeble prior to completion of cause of death? Completed 2 No 1 Yes 1 ☐ Yes 2 ☑ No or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) 2 No Other: 4□ Nursing Homa 5 Residenca 6 □Other (Specify) 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death Certification: 28e. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending death. investigetion 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 281, Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicida To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 🗹 Certifying Physician: To the best of my knowledga, deeth occurred at the time, dete end place, end due to the cause(s) end manner as stated. Medical 29a. Certifiar 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, deta end pieca, end due to the ceuse(s) and mennar stated. 29b. Signeture end titla of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 1)23809 ster w 30. Nema end eddress of person who complated comise of deeth (Itam 23a) (Type, Print) Dayle Cancer Ctr. 22 S. Greene St., Book. MI Greenelouin Viestia 31. Date filed (Month, Day, Year)

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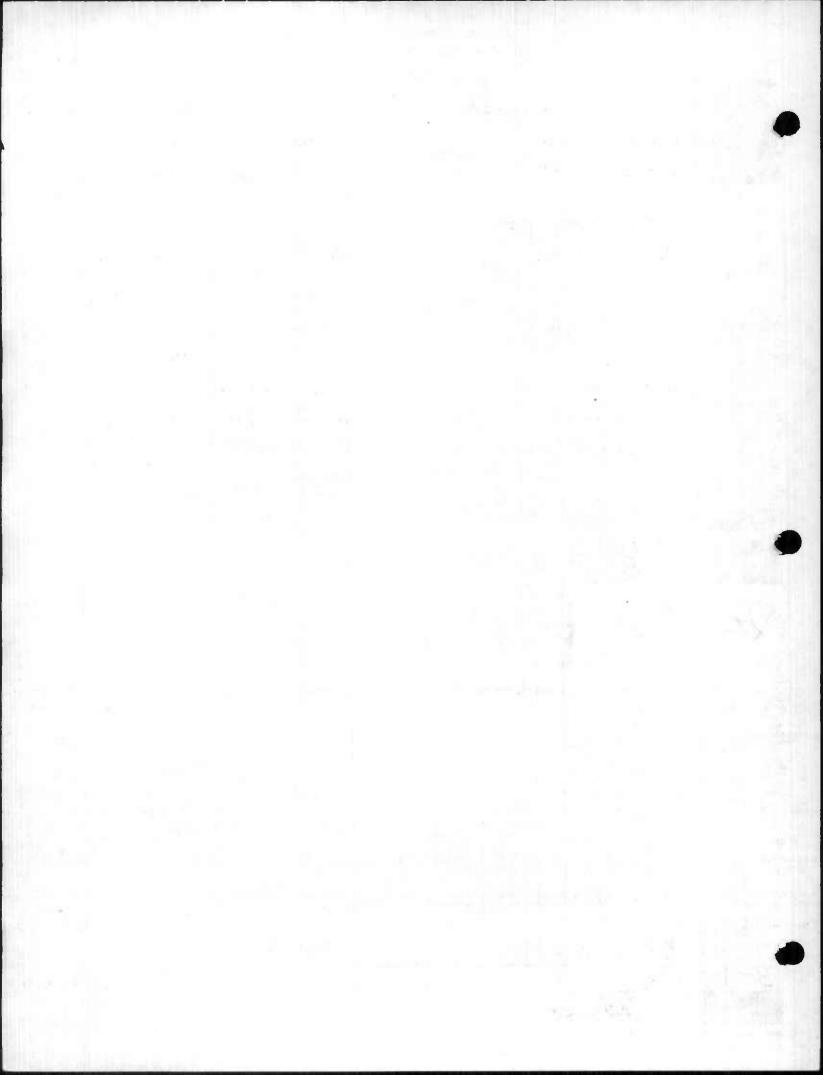
32. Registrer's Signeture

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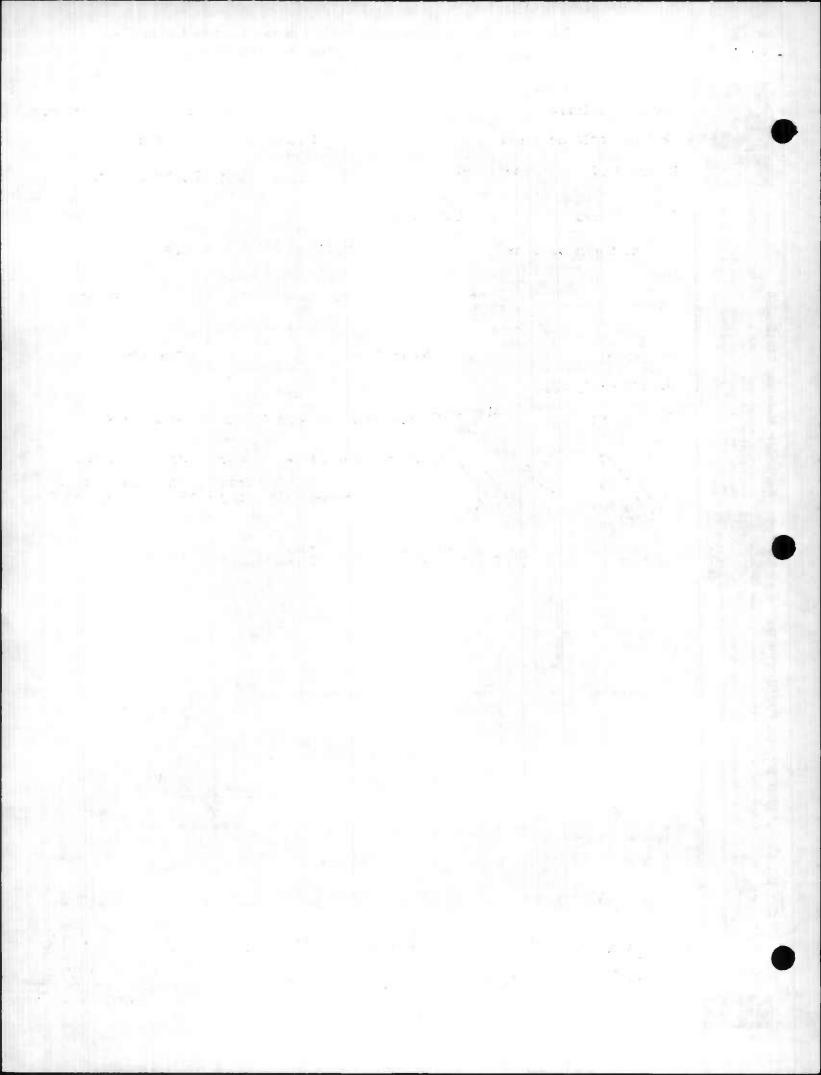
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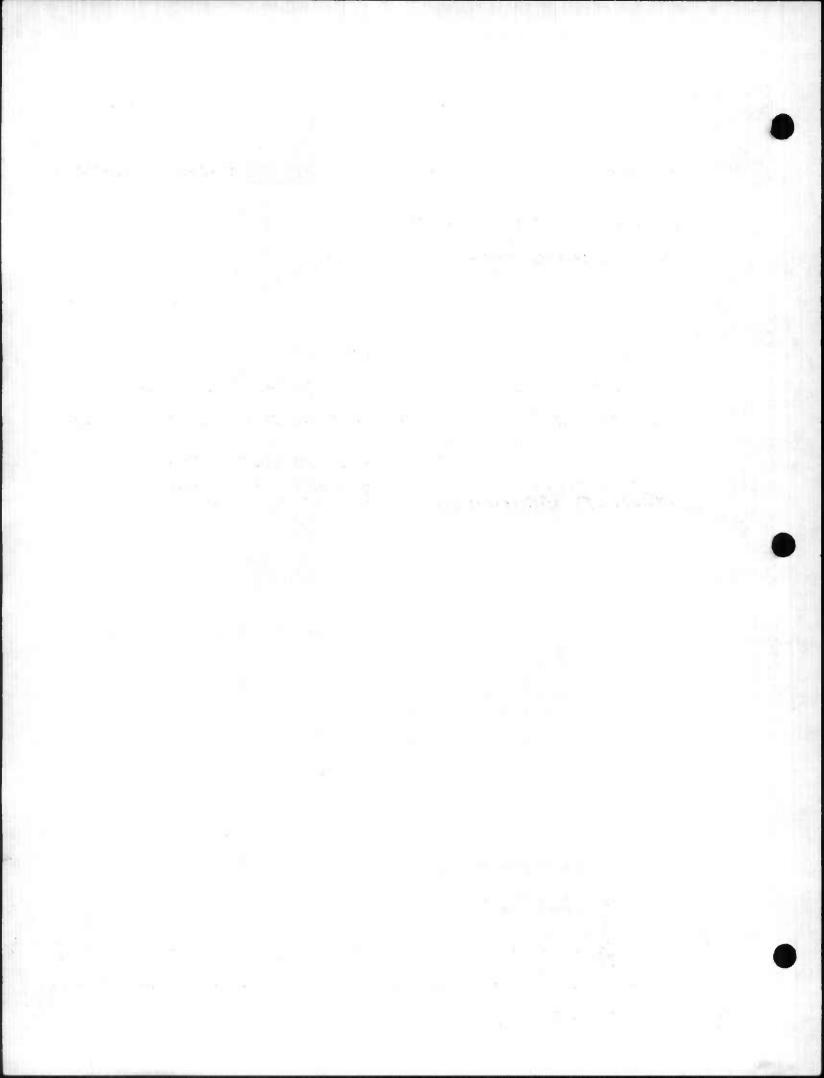
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	Physic /Medi		1. Decedent's Name (First, Middle, Last, HELEN A.	BYR	NE				2. Deta of D Month	eeth Dey	Year 958	3. Time of Death
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		ior	Usuel Residence of Decedent 10e. Stete 10b. County MARYLAND	N/A	10c. City, Tow				I		11	0d. Inside City Limits
	72 hours after death with the Maryland natural; or items 23s or 28s-f show dical Examiner must be notified at	Funeral Director	10e. Street and Number 104 S. WASHINTO		T	10f. 2	Zip Code	231 ispanic Origin? (Sp	noth, Voc or h	10g. Citizen of N		
0020	72 hours after dea "natural", or items edical Examiner m	þ	1 Navar Merriad 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N if Yes, Give Yaar or Datas;		If Yas, s	2 □XNo	n, Mexican, Puerto Specify:	Rican, atc.)		ck, Whita,	
21215-0020	d within giene. r than "	Completed	15. Decedent's Edu (Specify only highest gradi Elementery/Secondery (0-12) 6 YEARS	cation e <i>completed</i>) College (1-4or 5-	+)	Decedent's U: (Give kind of the bife. DO NOT	work dona d use retired	ation furing most of work)	ing	OWN I		lustry
Maryland	should be filed ind Mentel Hygir i marked other umatic event, ti	To Be (17. Father's Nema (First, Middle, Last) FRANK SZCZERBIC 19e. Informant's Neme/Relationship (Ty		400	. 8.6-Hi A dal	(044	18. Mother's Neme	NE KR	USZYNSI	ΚA	0.41
	tealth a mm 27 is ther tra		MRS . RUTH CHES 20e. Method of Disposition **D Burial 2 Cremetion 3 DR		20b. Place 0	B S. 1 f Disposition (A	WASHI	INGTON S	Dete	LTO . MI	0. 2:	1231
Baltimore,	permit. Pages Department of i Important: If its any injury or of once.		4 Donation 5 Other (Specify) 2) Specification of Funeral Sympton License		ST. S	22. Nema	and Addres	CEMETER of Fecility SKI FUNE		BALTO. OME	MD.	
	Physician		23a Part I. Enter the disease, or complishock, or heart feilure. List only or	icetions that causad ne cause on each line	the death. Do			ET ST. E g, such as cardiac			1224	Approximate Interval Between Onset and Death
	/Medical Examiner	Jer.	Immediate Cause (Finel disease or condition resulting in deeth)		OUD to (or es e	consequence o	of):	AREJA	7		-	OHOMI,
68760,	Part of the Contract of the Co	dical Examine	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	c	Due to (or es e	consequence	BOLISM				240.	
Box 6	death certific e attending p ad for use as	Physician/Me	Post II. Other significant conditions co	to Don't	12h Did tahana una cartellista de the							
P.0	gned by the	by Phys	Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert i CONCESTIVE (FEART KALLURE						23b. Did tobacco use contribute to the cau 1 ☐ Yes 2 ⋈ No 3 ☐ Probably		bably 4 Unknown	
of Vital Records,	hes t	Completed				-			per	s en autopsy formed?	coi of c	ere autopsy findings alleble prior to mpletion of cause deeth?
ital	ician: The L certificate he rector, page	Be Co	25. Wes case refarred to medical exeminer?					26. Place of Deet	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No sth (Check only one)			
ion of V	ing Phys h. After this funeral di	2	27. Menner of Deeth Noturel 5 Pending Accident Investigation	28a. Date of Injury	28e. Date of Injury (Month, Dey Year) 28b. Time of Injury V			er: 4 Nursing Home 5 Residence 6 Other (Spe			0	
Division	크 등 등 등	il Certification:	3 Sulcide 6 Could not be determined	28a. Plece of Injuit building, etc.	(Specify)	- 1200 1200			City or To	(Street and Numb own, State)		
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical		elclen: To the best of ner: On the basis of end menner stet	examination an	d/or Investigeti	on, in my of	olnion, death occurr	end due to the ed at the time	, dete end plece, 29d. Dete signe	and due to	the cause(s)
	8 4 8 4		1	ompleted cause of de	eth (Item 22a)			52102		MAY !	31,	1998
	Sta Registr		31. Data filed (Month, Day, Year)	ADA M.D		12014 14	-05,191	TAL 1001	V. 1312	OAD WAY	/ 131	ALTIMENE, M



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 7:30 P.M. SYLVIA BURDEN 1998 May 27, 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 10703 Bucknell Drive Montgomery 5. Social Security Number ff Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 F Yrs. 202-03-6161 80 March 27, 1918 New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Na Yes 2 □ No Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 10703 Bucknell Drive 20902 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 1 ☐ Yes 2020No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 302 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Isadore Friedman Katie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Burden, Daughter 10703 Bucknell Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/29/1998 20a. Method of Disposition 20c. Location - City or Town, Stefe Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Haym Salomon Cemetery Frazier, Pennsylvania 21. Signature of Funeral Service Licenses STEIN "HEBREW FMEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012 23a. Part1. Enter the diseasa, or complications that ceusad by death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line Immadiate Cause (Final disease or condition resulting in deeth) SERSIS Due to (or as a consaquance of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

by

Completed

Be

2

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after death w Department of Health and Mental Hyglene.
Important: If liem 27 is marked other than "natural" or the filling or other traumatic even.

with the Maryland

Records, P.O. Box 68780 950 signed by the a Division of Vital

page 2 Hospital or Attending Physician: 724 hours effer death.
Funeral Director: After this certifica stelly filled in by the funeral director, p To the Hospital or within 24 hours eff To the Funeral Di completely filled in

State Registrar

Examiner Physician/Medical þ Completed Be 2

Certification:

ca

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1 Yas 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accidant 6 Could not be datermined 3 Suicide 4 Homicida

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🔁 CertifyIng Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and mannar as stated.

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29c. License number

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha fima, date and piece, and due to the cause(s) 29d. Dete signed (Month, Dey, Year)

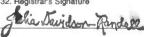
28f. Location (Street and Number or Rural Route Number, City or Town, State)

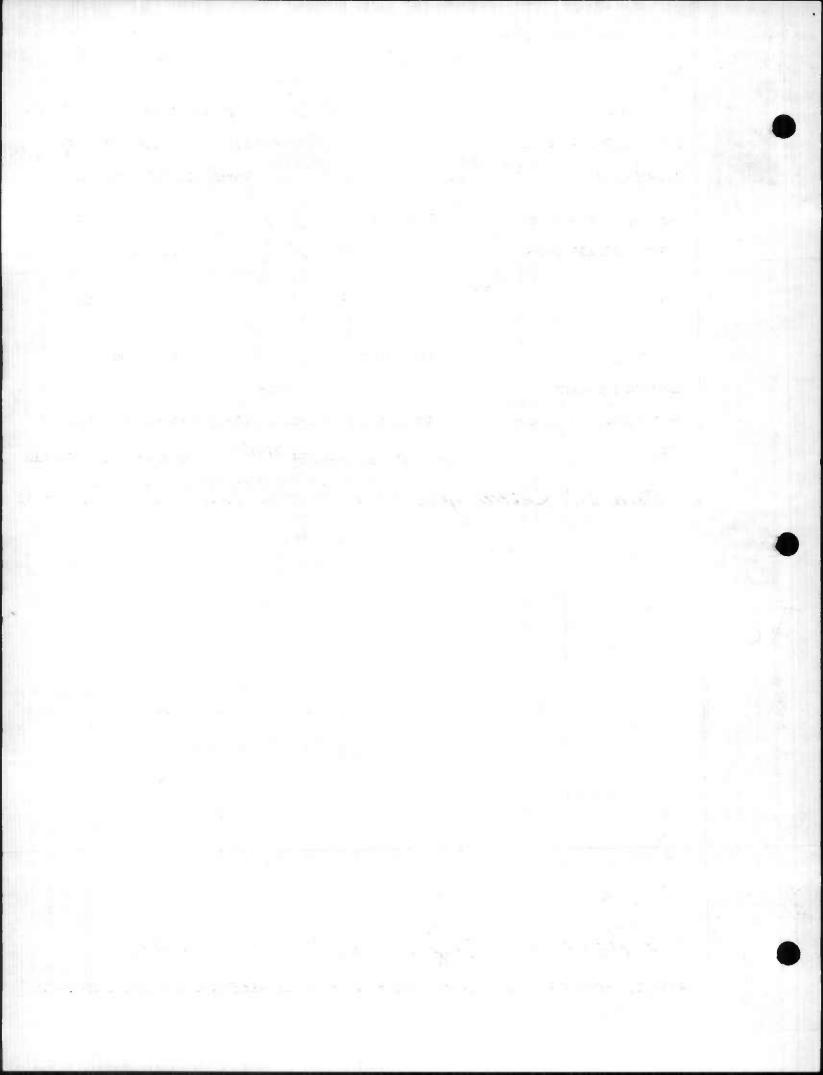
28d. Describe how injury occurred

30. Name and addrass of person who complated ceusa of death (Ithin 23a) (Type, Print)

Lila T. McConnell, M.D., Spence Center, 2 Wisconsin Circle, Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JUN 0 5 1998





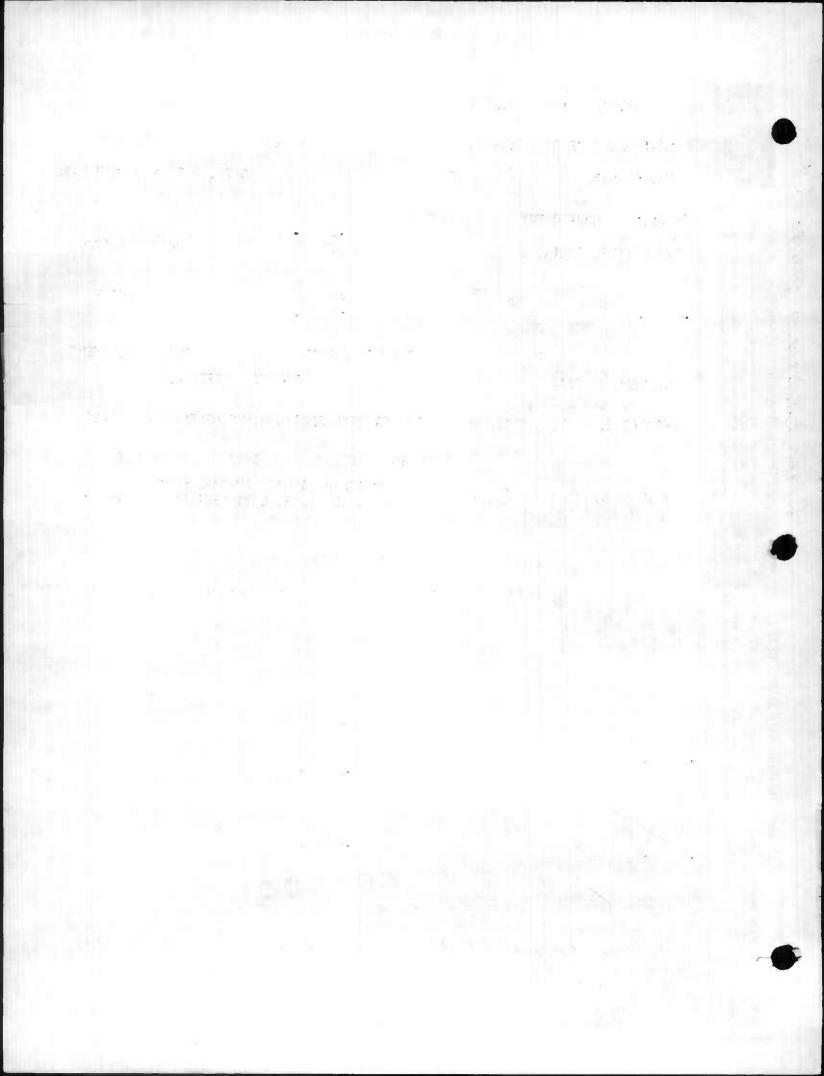
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1 Decedent's Name (First Middle Last) Month **Physician** BRUNER 27, 1998 BARBARA 4:40 PM MAY /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) **Examiner** MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 25, 1945 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 218 F Days Hours MARYLAND Yrs. Director 215 44 5565 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "netural", or items 28e or 28e-f show eny injury or other traumatic event. It is a second to the sec 10a, Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits **ASHTON** 1 ☐ Yes 2 No **MONTGOMERY** MD. Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20861 114 CRYSTAL SPRING DRIVE Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 25 Married SpecifyWHITE 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Bruner, Barbara A Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT SCIENCE EDITOR 12 18. Mother's Neme *(First, Middle, Majden Surname)* DOROTHY OFFERMAN 17. Father's Name (First, Middle, Last) Be RUSSELL FAIR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 114 CRYSTAL SPRING DRIVE, ASHTON, MD. 20861 CHARLES J. BRUNER, HUSBAND 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Slele 6/1/98 ROCKVILLE, MD. PARKLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MURIFI H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** 112 MONTHS /Medical Immediate Cause (Final disease or condition resulting in deeth) CERBBRAZ DISGASE MORRSTATIC Examiner Due to (or es e consequence of): Examiner 21/2 YEARS COLORDETAR MOTOSTATIC archon A and Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Box 68760 ž Physician/Medical Due to (or as a consequence of): -865 23b. Did tobecco use contribute to the cause of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 3 Probably 4 Unknown E. 1 Yee 2 No ģ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) To Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò 12 Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(e) and manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of cartifier MAY 27, 1998 D42452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA KA JAGOPAL, M.D. PHILIP DRIVE, SUITS 327, 18/11 pRINCE OLNEY, MD 20832

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 5 1998

32. Registrar's Signature

2. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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- 1	- /	U	and a	

DANIEL CLASH, III Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month Day **Physician** JUNE 02, 1998 0919AM DANIEL CLASH III * /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner LIBERTY MEDICAL CENTER E.R. BALTIMORE CITY NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Yrs. Director 45 MD 219-56-6867 Usual Rasidance of Decedant the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-(show other traumatic avant, the Modical Examiner must be notified at 1 Yes 2 □ No Director BALTIMORE MD NA 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with U.S.A.

14. Race - American Indian, 21207 Funeral 4001 Dorchester Road

1. Marital Statua

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours effer on the Mental Hygiene. Is marked other than "natural", or itse Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ BLACK Completed 15. Decedent's Education (Specify only highest grede completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) College (1-4or 5+) 9th GRADE LABORER BEER COMP. GUNTHER 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be DANIEL J. CLASH JR. MAGGIE HYMAN 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Peges 1 end 2 st Department of Health end Important: If Itam 27 is in any injury or other traum MAGGIE CARTER-MOTHER 20b. Place of Disposition (Neme of cametary, crametory or other place)

A OOL DORCHESTER ROAD BALTO MD 21.207

20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN CEMETERY 6/6/98 BALTIMORE, MD 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility MARCH F/H WEST A300 WABASH AVE, BALTIMORE MD 21215

Enter the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest,

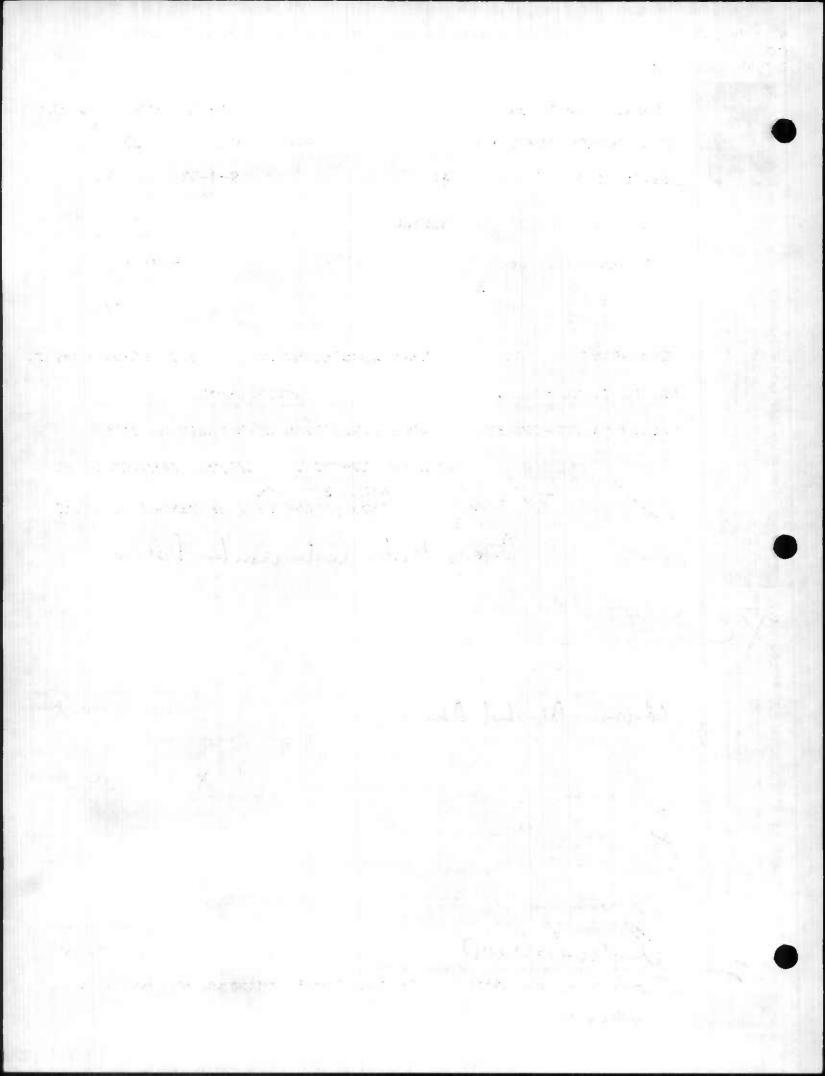
Approximate Interval Batw. Interval Batween Onset and Death **Physician** /Medical Immadiata Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to Immediata ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760: Due to (or as a consequence of): Physician/Medi 950 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? P.O. 3 Probably 4 Unknown signed by 1 ☐ Yee 2 ☐ No Records, þ 24b. Wera autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed 1 Yes Yas 2□ No 2 | No Division of Vital 25. Was case raferred to madical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1XYes 2 No 1 ☐ Inpatient 2 N ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Affer Natural 2 Accident Attanding 5 Panding death. 1 ☐ Yes 2 ☐ No Investigation or Attand efter death Director: 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) P 4 Homicide Hospital 24 hours e Funeral D edicai 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as etated 2XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29b, Signativ 29c. License number JUNE 03, 1998 O.C.M.E.

State Registrar ARON Locket, MD

111 Penn Street, Baltimore, Maryland 21201

32 Registrars Signature Translate 31. Date filed (Month, Day, Year) JUN 0 5 1998

30. Nama and addrass of person who completed ceusa of death (Item 23a) (Typa, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** /Medical 4c. County of Desth 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number, Examiner If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Days Hours 1 M 2 F 2 Yrs. -44 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Haalth and Mental Hygiane. Important: If item 27 is marked other than "naturest, or items 23a or 28a-f show any injury or other treumstic event, the Medical Examiner mass the nutrition. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maeyland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21234 Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Maritai Stetus 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ⊠Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) nomemako MENOW 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Ral 19e. Informent's Name/Relationship (Type, Prjnt) Virginia 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition May 29 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Vans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 6876 Physician/Medical equenca of): 2 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown signed t by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed page 2 s Sec 2 No cartificata Hospital or Attending Physician: funeral director. 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) daughters 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? After 1 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined To the Hospital or Atterwithin 24 hours after dei To the Funeral Directo complataly filled in by th 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end manner es steled.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar

31. Dete filed (Month, Dey, Year) JUN 0 5 1998

30 Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

29b. Signature and title

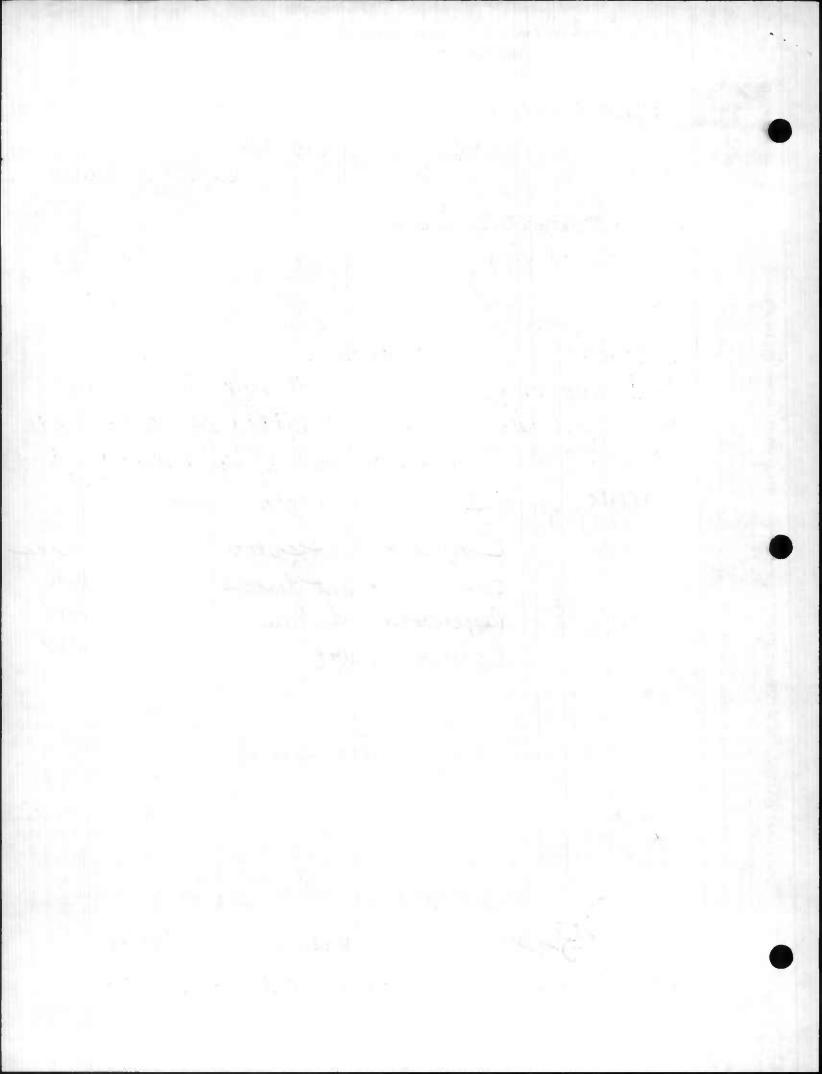
5601 32, Registrar's Signeture Mia Davidson Bandalle

29c. License number

D 22652

29d. Date signed (Month, Dey, Year)

Baltinose Md 21239



Physician /Medical Examiner

attending physician end for use es the bunal-transit

98

Physician/Medical

Be

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Certification:

P.O. Box 68760,

Records,

Division of Vital

Attending

death.

To the Hospital or Attendit within 24 hours effer death.

To the Funeral Director: A completely filled in by the fu

After this

Physician

/Medical

Examiner

MD

Director

à

Be

Funeral

Director

7 is marked other than "naturel", or itsems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "s

Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Last

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

Diaben's mellins

History of pulmonary emboli and thromb-phobilis

24b. Were autopsy tindings aveilable prior to 24e. Was en autopsy performed? completion of cause of death? 1 Yes 2 No

26. Piece of Deeth (Check only one) 1 Yes 2 No 1 Manpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Deeth 5 Pending Investigation 1 Naturel 2 Accident

6 Could not be

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier

3 ☐ Suicide

4 Homlcide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner es steted.

2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) and menner stated.

29b. Signeture end title of certitier

25. Was cese reterred to medical

29c. License number

Das gupta 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Nozli McDonnell PhD

MD

P 12000

June Seand, 1998

Registrar

31. Date tiled (Month, Day, Year) JUN 0 5 1998 32. Registrer's Signature Little Savidson-Rondone

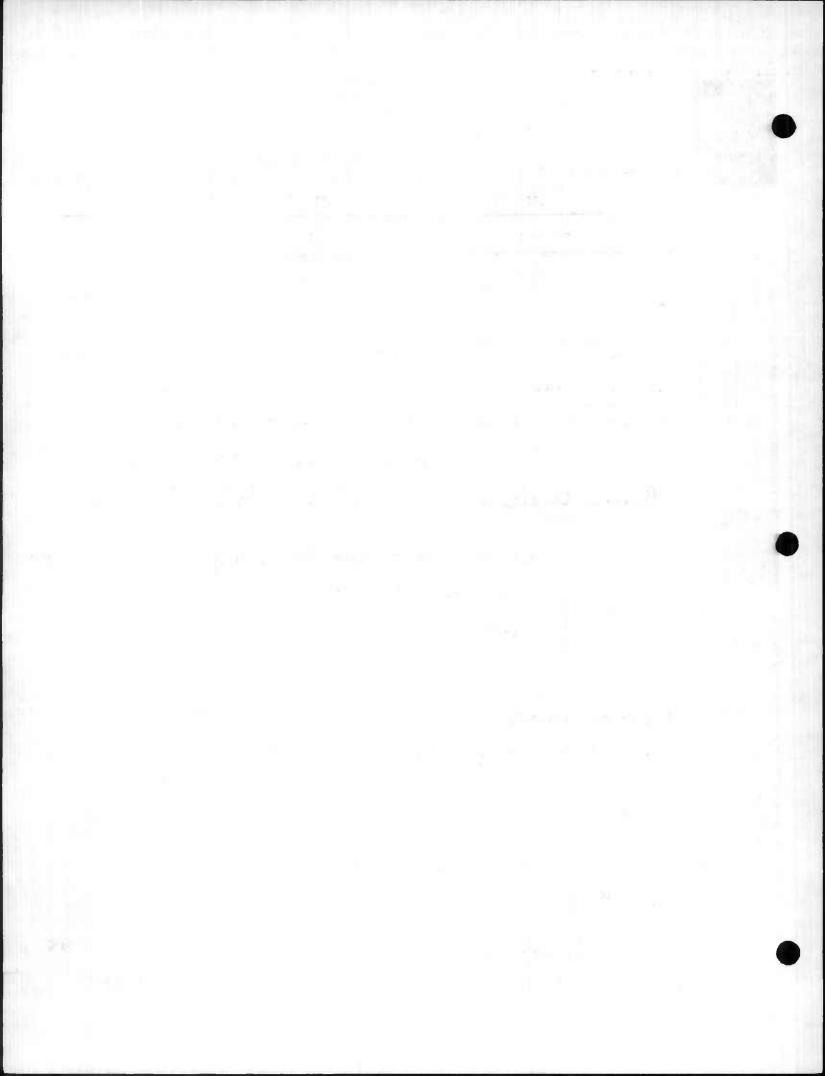
28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

DHMH 16 Ray 6/95

262 Hunters Ridge Rd Timonium mD 21093

29d. Date signed (Month, Day, Year)

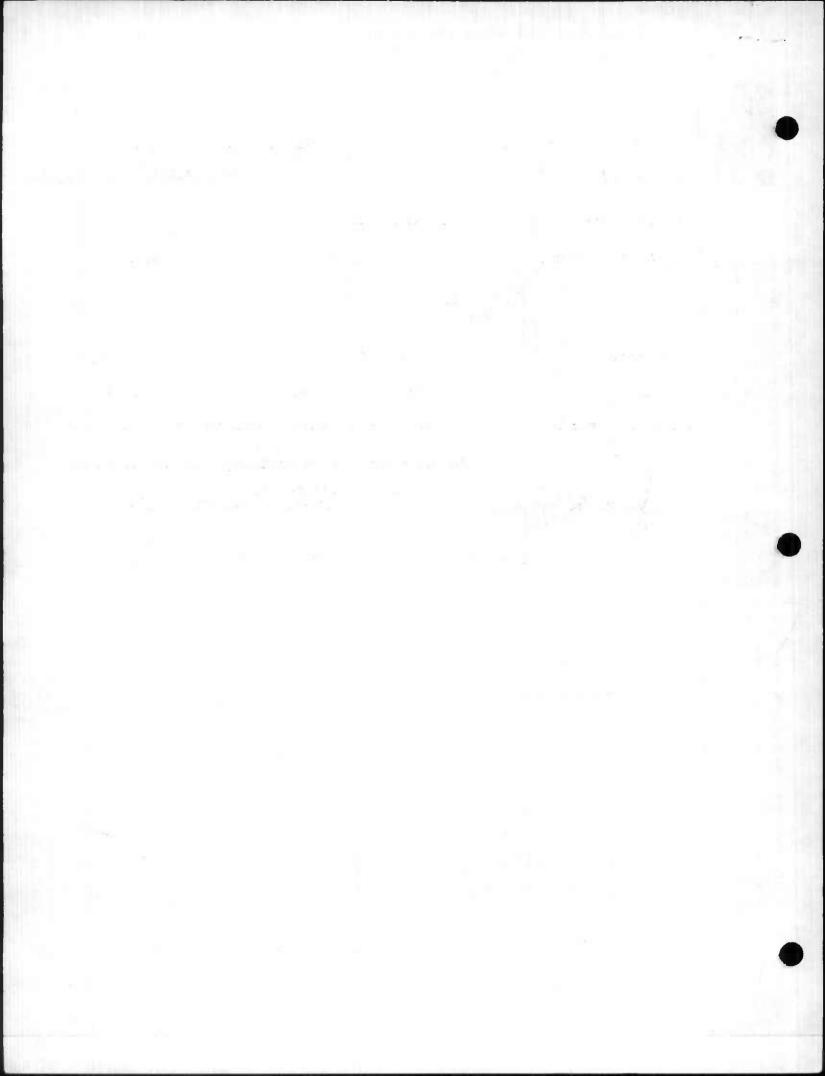
28t. Location (Street end Number or Rural Route Number, City or Town, Stete)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		:			Cert	ificate of			Reg. No.	0 1	1399		
Physicia /Medica	_	1. Decedent's Name (First, Middle, L				CRO	MER	2. Date of De Month TUN E	Day	Year 199	3. Time of Death		
Examine	r	4a. Facility Name (If not institution, g		")			4b. City, Town, or		h 4c. County	of Deeth			
		Good Samaritan H	-			Millerdon d Von	Baltimore	e City	N/Z				
Funeral Director		5. Social Security Number 6. 216-38-3697 Usual Residence of Decedent	Sex 7. A 1 M 2 □ F	ge (In yrs. les	Yrs.	Months Day		March	th ey, Year) 14,1942	9. Birthpla Count West	ace (State or Foreign ry) Virginia		
yland		10a. State 10b. County		10c. City,	Town or Loca	ation				10	d. Inside City Limits		
Mar.	to	Maryland N/A		Balt	imore	City					1 X Yes 2 □ No		
or 28	Z E	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Count	ry?		
23a	9	4207 Berger Aver	iue			21206			U.S.A	.A.			
urs a	by Funeral Directo	11. Marital Status 1 □ Never Married 2₺ Married 3 □ Widowed 4 □ Divorcad	12. Was Decedent Armed Forces 1 1 Yes 2 If If Yes, Give Year or Dates	? L/15/6()_ 10	as Decedent of Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify	a - America ck, White, e			
72 ho	Completed	15. Decedent's E	ducation		16a. Decede	nt's Usual Occi	upation	addin a	16b. Kind of B	usiness/indu	ustry		
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filed wi Hygien rther th	5	8th Grade			Plum	ber			Plumbir	ng Con	pany		
d offi	e n	17. Fether's Neme (First, Middle, Las	t)				18. Mother's Na	ime (First, Middle	, Meiden Sumen	ne)			
2 should be if and Mental H is marked of aumatic ever	0	David			Cromer		Ora			nipple			
h and list		19a. Informant's Name/Relationship					et end Number or F						
other tr	-	Karen E. Cromer/W	Date	ore, Maryland 21206 20c. Location - City or Town, State									
Pages nent of I nt: if its		1 ☐ Burial 2 ☑ Cremation 3					(ece) 6/3/9						
교 등원공 .	-	A Donation 5 Other (Specify) Baltimore/Washington Crematory Laurel, Maryland 21. Signal a of Funeral Service Licensee 22. Name and Address of Facility John C. Miller, Inc. 64.15. Pollair Pond Pollaimere Maryland 21.206											
Depa impo eny i	1												
	-	Juanita R	Homas		641	5 Belai	r Road,	Baltimor	e, Mary				
	П	23s. Part1 thater the disease, or con shock or heart failure. List only	one cause on each	d the death. line.	Do not enter	the mode of dy	ring, such as cardia	ac or respiretory a	rrest,		Approximate Interval Between Onaet and Death		
Physician /Medical	1	Immediate Cause (Finei	- 0		- 0	0	10 0		0.5	I I	Onaet and Death		
Examiner	1	disease or condition resulting in death)	. ISC	HEN	IIC	(AK DI	MAY	DIATE	/			
	6			Due to (or a	s e consequ	enca of):			/				
n arrivation		b. ————————————————————————————————————											
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0 0 0	edical	that initiated events			i								
ig phy as th	9	resulting in death) Last		Due to (or as	s a conseque	mice oi).				1			
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0 0 2 12	100	Part II. Other algolficant conditions	contributing to death !	out not resulting	na in the una	lertving cause o	iven in Part I	23h Did	tohacco usa co	ntribute to	the cause of death?		
tithe	lay.	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.							Yes 2 No				
5 50 .	o,	AAAA											
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N 22 4	Did.									com of de	pletion of cause eeth?		
The is	5							1 🗆	Yes 2 No	10	Yea 22 No		
entition schor,		25. Was case referred to medical examiner?					26. Piace of De	eth (Check only	one)				
a de S	0	1 ☐ Yes 2₽No	Hospitai:	ent 2□ER	VOutpatient	3□ DOA O	ther: 4 Nursing I	Home 5□ Resi	dence 6 Oth	er (Specify))		
Attending Ph or death. Sector: After th by the funeral	anon:	27. Manner of Death 1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident Investigation		ay Year) 28	3b. Time of Injury	28c. Inj	uryat ork?]Yes 2∐No	28d. Describe	28d. Describe how injury occurred				
2 등등 6	Yal milk	3 Suicide 4 Homicide 6 Could not be determined 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Ro City or Town, Stete)							Roufe Number,				
hour men y till y		29a. Certifier (Check only one) 1 ☑ Certifying Pl	nysician: To the best miner: On the basis of and manner si	of examination	dge, deeth on and/or inve	occurred at the t stigation, in my	time, date end piec opinion, deeth occ	e, end due to the urred at the time,	cause(s) and ma dete and placa,	inner as sta and due to t	ited. the ceuse(s)		
within 24 To the Fu completed		29b. Signature and title of cartifier				29c. Licer	se number		29d. Date signe	d (Month, D	ley, Year)		
cx		Jadi Mark	; M.r	> .		P	11401		TUNE	1	1998		
19	- 1	30. Name and eddress of person who	completed cause of	deeth (Item 23	3e) (Type, Pr	int)							
1		FADI EL MERHI	5601	L OCH	RAVEN	BLVV	, BAL	TIMORE	М.	v>.	21239		

Registrar DHMH 16 Rev 6/95



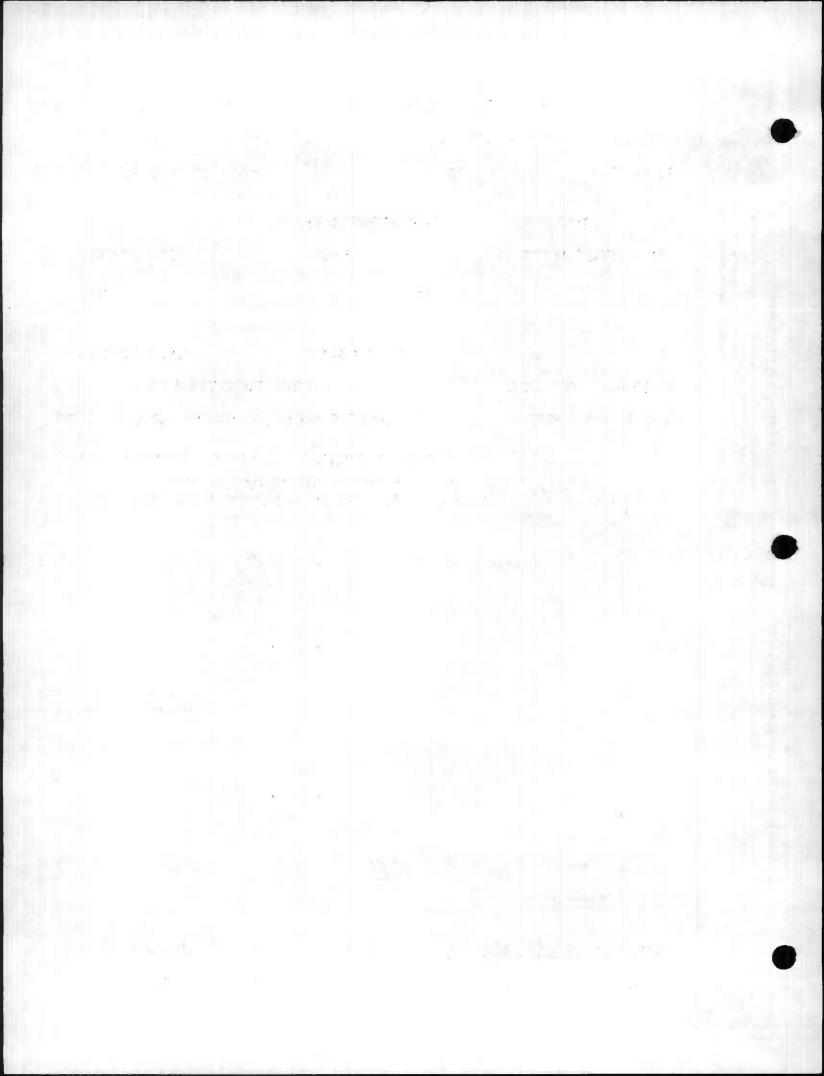
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth MAY 31, **Physician** HAROL D Τ. DEAN 7:35 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GAITHERSBURG MEDIPLEX OF MONTGOMERY VILLAGE MONTGOMERY If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Months, Deys Hours | Min | MARCH | 21, 1920 5. Sociel Security Number 9. Birthplece (State or Foreign Country)
WEST VIRGINIA 7. Age (In yrs. last birthdey) **Funeral** 12 M 2□ F Months Yrs. 78 219 05 2710 Director Usuel Residance of Decedan Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Int! If Hem 23 or 28-4 show int! If them 27 la marked other than "natural", or items 23 or 28-4 show any or other traumstic avant, in Assurant Engineer. 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 TYes 2 No Director MD. MONTGOMERY WASHINGTON GROVE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 304 CHESTNUT AVENUE 20880 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No. if Yes, Give W.W.II Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Married 2 Merried Specify: WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustnass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) BUDGET ANALYST U.S. GOVERNMENT 18. Mothar's Nama (First, Middle, Maidan Sumeme) 17. Father's Name (First, Middle, Last) HAROLD D. T. DEAN, SR. PEARL IRENE VAN HOUTEN 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 la l any Injury or other trau 304 CHESTNUT AVENUE, WASHINGTON GROVE, MD. 20880 MABEL V. DEAN, WIFE 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burlal 2 □ Cremetion 3 □ Removat from State DARNESTOWN CEMETERY 6/4/98 DARNESTOWN, MD. 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenti MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23e. Pert1. Enfer the disease or complications that ceused the deeth. Do not enter the mode of dying, such as cerdlec or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete tntervet Batwean Onset end Death **Physician** /Medical Immediata Causa (Final diseese or condition resulting in deeth) a. Cercinoma of the prostate,
Due to (or as e consequence of):

cordely naturation 2905 Examiner Examiner and I-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediata cause. Entar Underlying Ceuse (Diseese or trijury that initiated avants resulting in daeth) Last Due to (or es e consequence of): physician ar Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): affending p signed by the all Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings eveileble prior to completion of cause of daeth? been si Completed 24e. Wes en eutopsy is certificate hes t director, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funersi Diractor: After this certifica stely filled in by the funeral director, g Be 25. Wes case referred to medicel exeminer? 26. Piece of Deeth (Chack only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 10 1 Yes 2€No 1 Inpatiant 2 ER/Outpetient 3 DOA Certification: 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding investigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Coutd not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptece of tnjury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours aff To the Funeral Di completely filled in 12 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the best of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. edical 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June: 1, 1998 D33443 30. Nema and eddress of person who complated ceusa of death (Item 23a) (Type, Print) Viers mill Rd Rockville, Md 20851 Alan R Polleck, M.D 809 31. Deta filed (Month, Day, Year) 32. Registrar's Signature State Alia Davidson Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day 9:20 a.m. June 1, 1998 4b. City, Town, or Location of Deeth 4c. County of Death

Birthpiece (State or Foreign Country)

10d. Inside City Limits

tntervel Between Onset and Deeth

Minutes

1 Year

24b. Were eutopsy tindings eveilable prior to completion of cause of deeth?

1 ☐ Yes 2 ₺ No

1 ☐ Yes 2 ☑ No

Hawaii

Bleck White etc

Physician /Medical Examiner

Funeral Director

the Maryland 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Medical Examines must be notified at death

Pages 1 and 2 should be filed within 72 hours after of the little and Mertal Hygiene.

Int. If them 27 is marked other than "natural", or feeling you other traumatic event, I'm Medical Energies.

Uny or other traumatic event, I'm Medical Energies. aftimore, Maryland 21215-0020 Department of Important: If

Physician /Medical Examiner

physician and s the burial-trans

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signed by t

page 2

director.

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this funeral

After

after death.

24 hours a Hospital

To the Hosp within 24 ho To the Fune completely fi

or Attending Physician:

the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

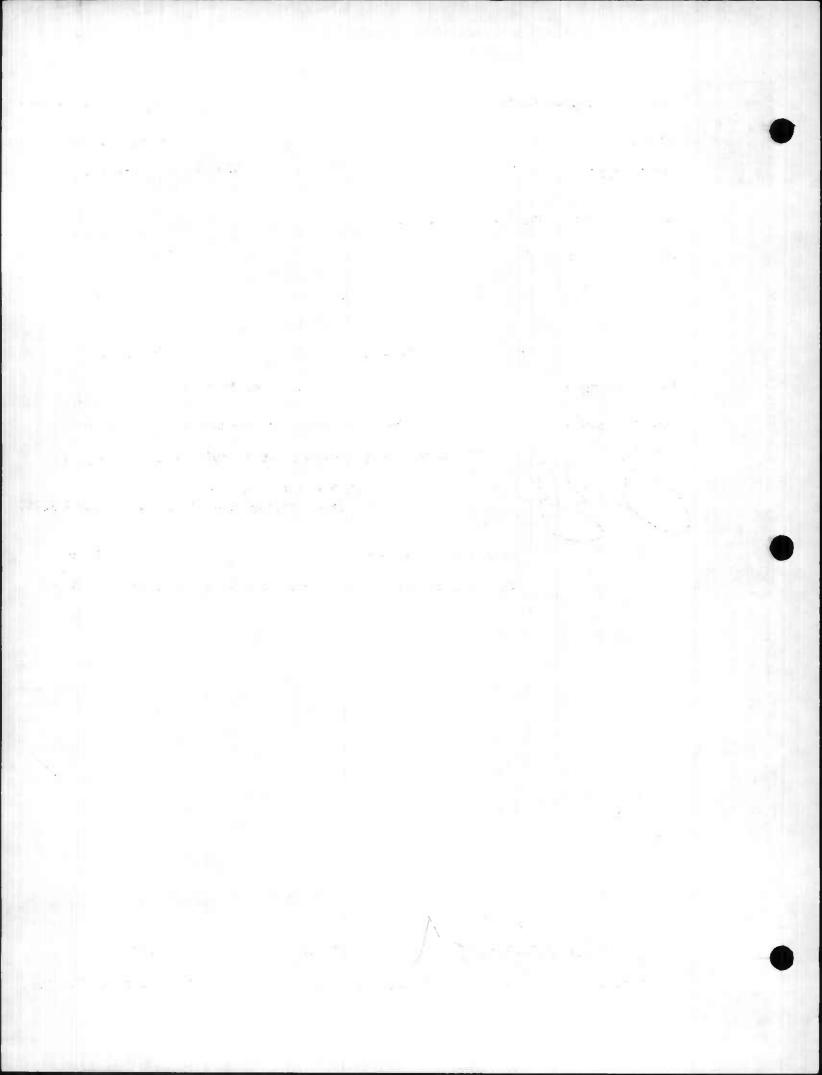
Elaine Rodriguez Dario 4e Facility Neme (If not institution, give street end number) 6700 Good Luck Road Lanham Prince George 8. Date of Birth
(Month, Dey, Year)
June 3, 1927 if Under 24 Hrs. 5. Sociei Security Number If Under 1 Year 7. Age (In vrs. lest birthdev) 1□M 2X F Months Deys Hours Min 70 Yrs 219-64-2550 Usuel Residence of Deceden 10a State 10h County 10c. City, Town or Location Director MD Prince George Lanham 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6700 Good Luck Road 20706 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Maritel Stetus 1 Never Merried 2 N Merried 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usuei Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Lest) Ramon Rodriguez Adeline Ferreira 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) Elmo Dario/Son 6700 Good Luck Road, Lanham, Maryland 20706 20b. Piece of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from Stete MD National Memorial Prk 6/6/98 Laurel, Maryland 4 Donetice 5 Other (Specify 22. Name end Address of Fecility uneral Service Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 er the mode of dying, such as cardiac or respiretory arrest, Approximete licetions that caused the deeth. Do not enter Immediate Ceuse (Final Respiratory Failure diseese or condition resulting in deeth) Due to (or es a consequence ot): Examiner Widely Disseminated Carcinoma of Urinary Bladder Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence ot): Physician/Medical Due to (or es e consequence ot): 23b. Did tobacco ues contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24e. Wes en autopsy Completed 1 ☐ Yes 2 No 25. Wes case reterred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Neturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gagtifier D02338 6/2/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Registrar

31. Dete filed (Month, Dey, Yeer)
JUN 0 5 1998

Richard P. Delaney, M.D. 9801 Georgia Avenue, Suite 1-11, Silver Spring, MD 20902 32 Registrar's Signeture a Davidson Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Ruth A. Dallman May 6:45 A.M. 30 1998 /Medical 4a. Facility Name (If not institution, giva straat and number) 4c. County of Death 4b. City, Town, or Location of Daath Examiner Crofton Convalescent Center Crofton Anne Arundel 5. Sociei Sacurity Numbar if Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) **Funerai** 1 M 2 F Months Days Hours Min 142 24 4334 Yrs. 88 Director Nov. 18, 1909 Riverside N.J. Usual Rasidanca of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show items 23a or 28a-f ehov 1 Yas 2 This Director Maryland Anne Arundel Crofton 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1816 Lang Drive 21114 by Funeral United States 11. Maritai Status Wes Dacedent Evar in U,S. Armad Forcas? Was Dacadant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Bleck, Whita, atc. traumatic event, the Medical Examiner 1 ☐ Yas 2 ☒No If Yas, Giva Yaar or Datas: 1 Never Married 2 Marriad ŏ 1 ☐ Yas 🏋 No Specify: White Specify: 3r Wildowad 4 □ Divorcad "natural", Completed 16e. Decadant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Dacadent's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than inty or other traumatic event, the Me Eiemantary/Secondary (0-12) Coilega (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Nema (First, Middla, Maidan Sumema) Fred M. Fichter Bertha M. Hozier 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Dorothy M. Page 1816 Lang Drive Crofton Maryland 21114 20b. Placa of Disposition (Nema of camatary, cramatory or other placa) 20a. Method of Disposition Data 20c. Location - City or Town, State PABurial 2 ☐ Cramation 3 ☐ Removal from Stata Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Spacify) Odd Fellows Cemetery June 3, 1998 Burlington N.J. 21. Signeture of Funaral Sarvice Licansaa 22. Name end Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 1. Entar tha disaasa, or com lock, or heart feilure. List only omplications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, nly one ceuse on aech lina. Approximata Intarval Batween Onsat and Death **Physician** /Medicai Immadiata Cause (Finel neumonia 2 heades disaasa or condition resulting in daath) Examiner Due to (or as a consequanca of): Examiner Omently Sequentially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in deeth) Lest Dua to (or as a consequence of): Rertension Physician/Medical Dua to (or es a consaguanca of): been signed by the atte should be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performad? 24b. Wara autopsy findings Completed available prior to completion of cause of deeth? 1 Yas 2 No 1 Tyas 2 No funeral director, 25. Was casa raferred to medical exeminar? Be 26. Piece of Deeth (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Natural 2 Accidant 1 Yas 2 No the 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) filled in by 4 ☐ Homicide edical 29a. Certifier 🕊 certifying Physician: To tha bast of my knowledga, daath occurred at tha tima, date and placa, and dua to tha causa(s) end manner es statad. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the causa(s) and manner stetad. (Check only one) To the To the To the 5 29b. Signeture end titla of certifier 29c. Llcansa number 29d. Dete signed (Month, Day, Year) Neme end address of person who completed cause of daeth (Itam 23a) (Type, Print) y arres 7845 Oakwood Rd P200 Glen Burnie MIS MD 31. Deta filed (Month, Dey, Yaer)

State Registrar

JUN 05 199

32. Registrar's Signatura uta Davidson

with the Maryland

filed within 72 hours after death

21215-0020

Baltimore, Maryland

Box 68760

Division of Vital Records, P.O.

The law requires that the death certif

has certificate

i or Attending Physician: after death. Director: After this certifica

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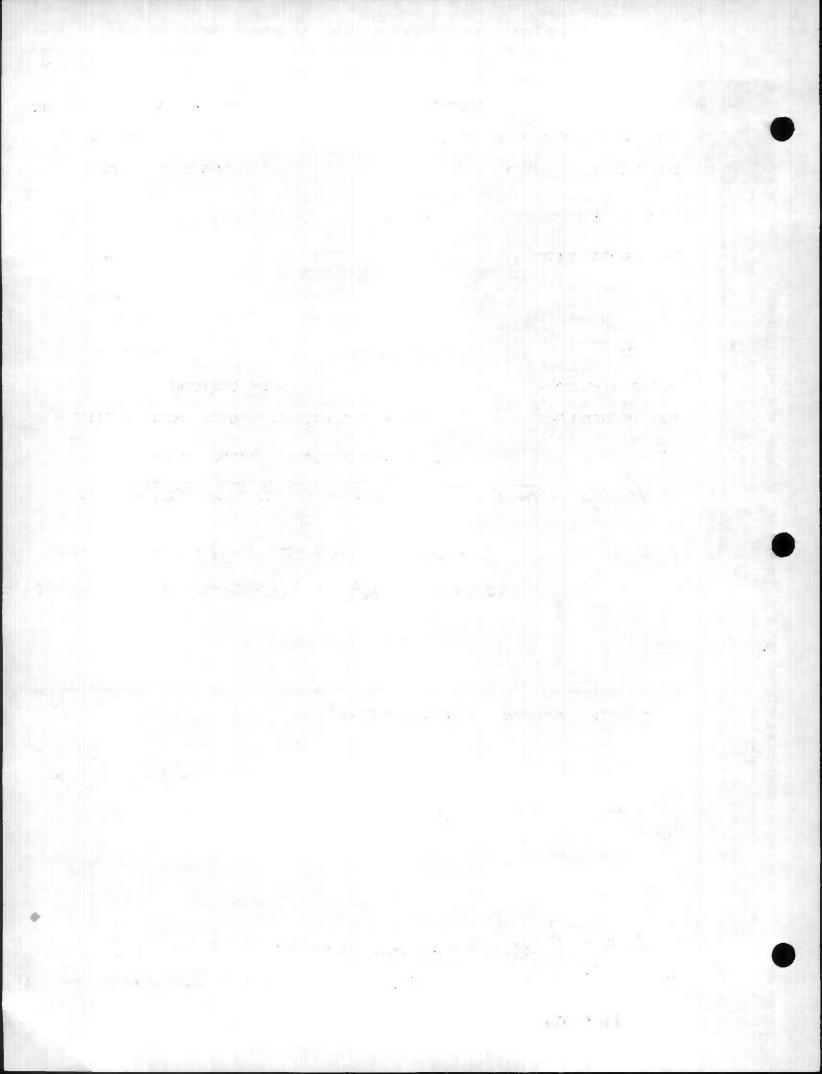


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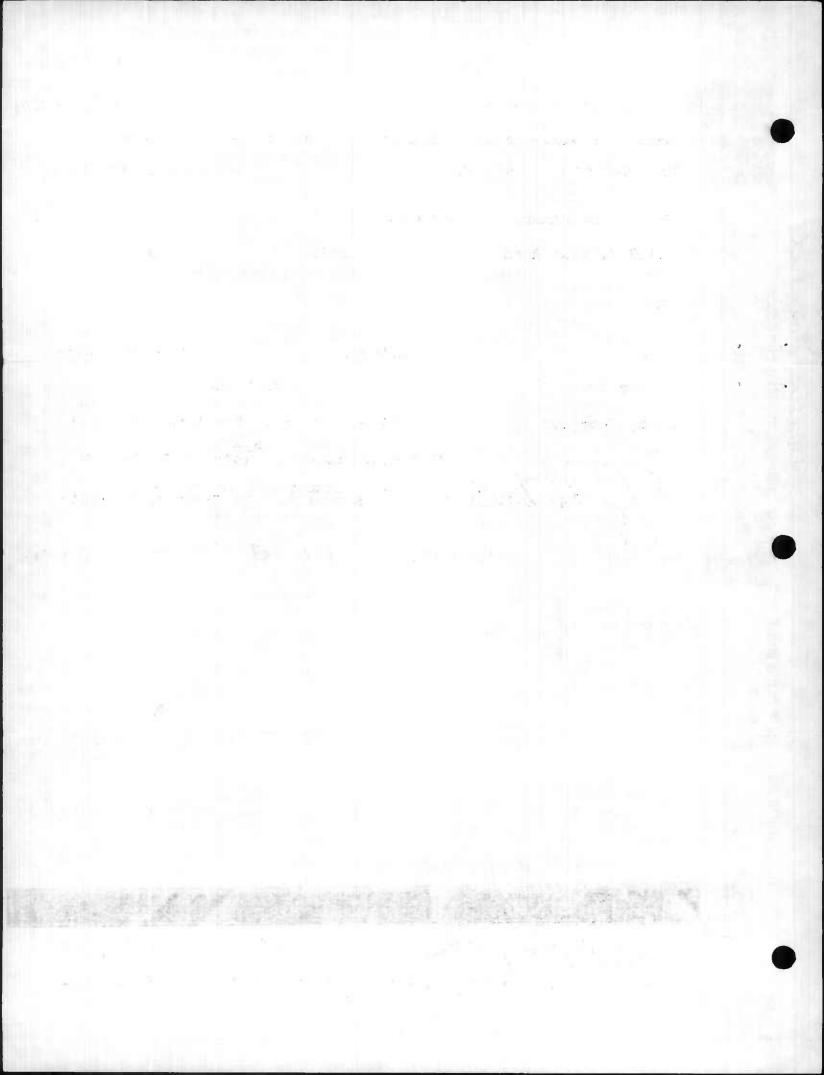
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Fune Direc		5. Sociel Security Number 061-52-1054	6. Sex 1 M 2		ge (In yrs. k 91	est birthdey) Yrs.	If Under Months	1 Yeer Deys	If Under : Hours	24 Hrs. Min,	8. Dete of Birth (Month, Dey, 07/05/1	Yeer) 906	9. Birthpi Count IL	ece (State or Forei ry)	
ours after death with the Manyland rel', or terms 23a or 28a-f show Examiner must be notified at a by Funeral Director		Usuei Residence of Decedent 10a. State 10b. Count	hv .		10c. City	, Town or Lo	ocation						10	od. Inside City Limi	
	ō		ARUNDEL			SADENA								1√7 Yes 2□N	
r 28e	Director	10e. Street and Number	10e. Street and Number 10f. Zip							Code 10g. Citi				itizen of What Country?	
th wit	a O	657 ROSSBURG C	OURT				2	1122				U.S.A.			
	Funeral	11. Meritei Stetus	Armed	Forces?				gin? (Spe , Puerto	ecify Yes or No- Ricen, etc.)		e - America ck, White, 6				
s afte	by F	1 Never Merried 2 Ma 3 Widowed 4 Divorce	if Yes	es 2 🔯 , Give or Detes:	No		1□ Yes 2	No No				Specify	WHIT	E	
vithin 72 hours after ena. than *naturel', or ite	Ped	15. Decede	ent's Education			16e. Dece	dent's Usue	Occupa	ition			16b. Kind of B	usiness/Ind	ustry	
within 7.	pie	(Specify only high Elementery/Secondary (0-12)	est grade complet	ed) je (1-4or	5+)	(Give	kind of work DO NOT us	k done d e retired	u <i>ring</i> most	of work	ng				
filed will hygian other th	Completed	12				HOME	MAKER				400		HOME		
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Hygiena. To marked other than "naturel", or fraumstic year	Be	17. Father's Neme (First, Middle									(First, Middle, N		10)		
should be nd Mental marked o	2	ANTON BAUMGAR 19e. Informent's Neme/Reletion				19b. Meill	no Address	(Street e			(UNKNOW at Route Number,		State. Zio	Code)	
and 2 showalth and 127 le m		FRANCIS DUBIEL									SADENA,	-			
of Has	other treumatic avent, the M	20a. Method of Disposition			0.6		osition (Nem		e)	i	Dete 2	20c. Location -	City or To	wn, Stete	
nit. Pagas artment of a ortant: If the		VXBuriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (om State		RAYMO	ONDS C	EME	ERY	6	/6/98 B	RONX,	NY		
Baltimore, N permit. Pagas 1 and Department of Haalth Important: If Item 27	once	21. Signeture of Funerel Service	e Licensee	4			2. Neme end PERLIN 36 EDM				ERAL HOM	E, INC	Ď 212	28	
		23a. Pert1. Enter the diseese, shock, or heert feilure. Li	or complications that	et ceuse	d the death									Approximete Intervai Between	
Physici	_	onout, or nout rollate.	or orny one oodso											Onset end Deeth	
/Medic Examin	_	immediate Ceuse (Finel diseese or condition resulting in deeth)	Θ	Ce	on GE	STIV	IE F	401	TSH	F.	FAILU	RE		YEARS	
		resulting in deetily			Due to (or	as e conse	quence of):				EALLU				
uted	Examiner		b	S V		es e conse		_/	NSU	M	cienc	- 7	1	YEARLS	
axecuted an and mal-transit	Exa	Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying	,		Due to (or	92 9 COUSE	querice ory.								
2	dicai	Ceuse (Diseese or injury c. thet initiated events purpose to (or es e consequence of):													
S. 6	9	d.													
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at the de doy the	ysi	Part II. Other significant condit						,	en in Pert I.		23b. Did to	-	ntribute to 3 ☐ Prot	the cause of deal	
F ta be	y P	CHRONIC	ATRIA	- 1	TIBR	114	47701	N				2010	3 1101	ALL THE TENT	
Of VICAL RECORDS, P. Physician: Tha law requires that this cardificate has been signed b	pel										24e. Wes er		eve	ere autopsy finding eileble prior to	
a law re	0												of e	mpletion of cause deeth?	
Tha Tha sata h	Co										1□ Ye	s 2000	10	Yes 2500	
Physician: Thatis this cartificate he dia director page	Be	25. Wes cese referred to medic exeminer?	Hospital:					Oth		of Deet	h (Check only on	ө)			
Physical direction	To To	1 ☐ Yes 2 ☐ No 27. Manner of Deeth	1	☐ Inpati ete of inji	-	P/Outpetie		-	4 🗆 190	-	me 5 Reside	-)	
ding the	tion	ViNeturei 5 ☐ Pend		Month, Da		injury	М	Bc. injun Worl	(? Yes 2□			,.,			
DIVISION or Attending after death. Director: After	Certification:	3 Suicide 6 Could	d not be 28e. P	iece of In uilding, e	jury - At ho tc. (Specify	me, ferm, st	reet, fectory	, office			28f. Location (St. City or Town		per or Rure	I Route Number,	
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director Affect his completely filled in by the funeral	edical C	29e. Certifier 1 Certify (Check only one) 1 Medica	ing Physician: To ii Examiner: On the end re	the best	of exeminet	vledge, deet ion end/or in	h occurred a vestigetion,	t the tim	e, dete en pinion, dee	d plece, th occurr	and due to the cared at the time, de	ause(s) end mete end plece,	enner as st and due to	ated. the cause(s)	
vithin Fo the	¥	29b. Signature and title arconfl					29c	. License	number		2:	9d. Date signe	d (Month,	Dey, Year)	
- > - 0		> Quelles	Til als	Att	700 Du	VZ M	5.	120	807			6/4/0	X		
1	0	30. Name and address of perso		euse of	deeth (Item	23a) (Type,	Print)					=1-	-	MS 210	
			1686	u.	7-		14	065	CRA	NY	twy BL	EN BUI	ENIE	MD 210	
	State	31. Dete filed (Month, Day, Yea	7) 3	2. Regist	rer's Signet	ure									

Registrar

JUN 0 5 1998 Julia Sevidour Randale



			•	aryland / D		k. Assure Al Health and M f Death	lental Hyg		B 17404
Physic /Med		1. Decedent's Name (First, Middle, Last) Margaret C.					2. Dete of Dea	29/	3. Time of Death 247 QM
Exami	iner	4a Facility Name (If not institution, give str Hospice of Baltim		Gilchri	st	4b. City, Town, or Lo		4c. County	of Death
Funera Director		5. Social Security Number 6. Sex 193-18-6802	7. Ag	e (In yrs. last birth	day) if Under 1 Yea	if Under 24 Hrs.	8. Dete of Birth (Month, Day Feb. 21	, Year) 25	9. Birthplace (State or Foreign Maryland
Maryland a-f show lifed at	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimo:	re	10c. City, Town Freela					10d. Inside City Limits 1 ☐ Yas 2 ☑ No
A MEN	Director	10e. Street and Number 2522 W. Ruhl Ro	224		10f. Zip Code 2105			10g. Citizen of V	
South South	Funeral		. Wes Decedent Armed Forces?	Ever in U,S.	13 Was Decedent of	Hispanic Origin? (Spo	ecify Yes or No-	14. Red	e - American Indian,
A 02		1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	No	If Yes, specify Cu	ban, Mexican, Puerto o Specify:	Rican, etc.)	Black, White, etc. Specify: White		
15-C	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. C	Decedent's Usual Occi Give kind of work don-	upetion e during most of work red)	16b. Kind of Business/Industry		usiness/Industry
212 212	ошо	Elementery/Secondary (0-12)	College (1-4or 5	i+)	Laborer	00)		Food F	rocessing
Iland up the file of the other	To Be C	17. Father's Name (First, Middle, Last) Harry Young				18. Mother's Neme	e (First, Middle, Hoffmar		ne)
Dudlee, maryla apes 1 and 2 ahout 1 in co Heath and Mary is it them 37 is marked for other traumatic.		19a. Informent's Name/Reletionship (Type	, Print)			et end Number or Run			
		Bobby Thompson 20a. Method of Disposition		20b. Piece of I	Disposition (Neme of	uhl Rd.,	ne 1,		City or Town, State
Dage of the part o		1 Burial 2 Cremation 3 Red	movai from Stete		cremetory or other pi etown Ce		ne 1, 1998	Freela	nd, MD
Baltimore, pamil. Pages 1 a Department of Heal Important: if them any Injury or other affice.		21. Supature of Funeral Service Ligensee	Kurk	ui	22. Name and Add J.J. Har		Mortua	ry,Inc	PA 17349
Physician /Medical Examiner		23a. Part / Enter the disease, or complication of the factor of the fact		-	et enter the mode of di		or respiratory ar	rest,	Approximate Intervel Between Onset end Death
760, e be axecuted rsician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b							
Box 687 leath certificate attending physis	in/Medic								
O. B a death ha atte	Physician/M	Part II. Other significant conditions contri	ut not resulting in	uiting in the underlying cause given in Part I.			23b. Did tobacco use contributa to the cause of death?		
cords, P.O. requires that the de been signed by the s	by Phy							Yes 2No	3 Probably 4 Unknown
Records, P.O. Bo The law requires that the death tte has been signed by the atter page 2 should be detached for a	Completed							an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec	Соп						101	/es 2□No	1 ☐ Yes 2 ☐ No
of Vita Physician: rthis certific	o Be	25. Was case referred to medical examiner?	spitel:	0□ ED/O-4		26. Plece of Deat			on comment Has his
n of ing Phy Whar this uneral of	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, De		me of ury 28c. inj	jury at //ork? ☐ Yes 2 ☐ No	28d. Describe h		ner (Specify) 1705 Al Ce
Division of Attending Parties and the fundamental properties of the fundamental parties of the fundame		3 Suicide 6 Could not be determined				е	28f. Location (S City or Tox		ber or Rural Route Number,
		29a. Certifier (Check only one) Check only one)							
25.55	E	29b. Signature end title of certifier	myfle	ley .		25205		201114	29, 1998
4		30. Name and address of person who com W. A. R. Ley	16Bm	9 67.	ype, Print) Y. Cl	harles St.	BAH	. md	29,1998
St Regist		31. Date filed Month, Dey, Year) UN 0 5 1998	Julia Julia	ar's Signature	and of				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Eschmann 1998 JUNE 3, 3:51 AM 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Saint Joseph Medical Center Towson Baltimore If Under 1 Yeer | if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Deys Hours Min 1□ M 20 F Yrs. August 8, 1911 86 Pennsylvania 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2♥ No Baltimore Towson 10f. Zip Code 10g. Citizen of Whet Country? 21204 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Homemaker Own Home

item 27 is marked other than "natural", or items 23s or 28s4 show other traumatic event, the Modical Examinar must be notified at death Funeral 1 and 2 should be filed within 72 hours after or Health and Mental Hygiene. em 27 Is marked other than "natural", or Her þ Completed Be

permit. Peges 1 and 2 s Department of Health ar Important: If item 27 is

any injury or

Physician /Medical

Examiner

physician and the burief-transit

85 950

signed by the e

page 2 s hes

After this

funeral

the death certificate be executed

Examiner

Physician/Medical

þ

Completed

Be

10

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

the Meryland

17. Father's Neme (First, Middle, Last) Charles 19e. Informent's Name/Reletionship (Type, Print)

8 years

Mabe1

5. Social Security Number

212-50-6609

Maryland

10a. Street and Number

10a Stete

Directo

Usuel Residence of Decedent

405 Alabama Rd.

1 ☐ Never Married 2 ☐ Merried

3 Nidowed 4 Divorced

Elementery/Secondary (0-12)

Eleanor MacQueen

10b. County

Broomal1

(daughter)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 627 Fairway Drive

Towson, Maryland

Utzv

20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) Moreland Memorial Park 20c. Location - City or Town, Stete Baltimore, Maryland

21. Signeture of Funerel Service Licensee

22. Neme end Address of Fecility
Mitchell-Wiedefeld Home, Inc.

Sarah

21212 6500 York Road Baltimore, Maryland 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Deeth

6-6-98

18. Mother's Neme (First, Middle, Meiden Sumame)

Immediete Ceuse (Final diseese or condition resulting in deeth)

RESPIRATORY FAILURE Due to (or es a consequence of)

CARDIOGENIC SHOCK

Due to (or es e consequence of)

MYOCARDIAL INFARCTION

ACUTE Due to (or es e consequence ot): DAYS

HOURS

DAYS

Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

RENAL INSUFFICIENCY

1 Inpatient

23b. Did tobacco use contribute to the cause of deeth? 2 No 3 Probably 4 Unknown 1 Yee

24e. Wes en eutopsy performed?

24b. Were autopsy findings evalleble prior to completion of cause of deeth?

26. Plece of Deeth (Check only one)

2 No

25 No

25. Wes case referred to medical exeminer? 1 Yes 25 No 27. Menner of Deeth 1 Neturel

5 Pendina investigetion

28e. Date of Injury (Month, Dey Year) 6 ☐ Could not be determined

Hospital:

2 ER/Outpatient 3 DOA 28b Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

4 ☐ Homicide

3 ☐ Suicide

TS Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

MM IN

29c. License number D 31826

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

LINTHICUM, RICHARD L. M. D. , 7620 YORK ROAD, TOWSON, MARYLAND

Registrar

JUN 0 5 1998



DHMH 16 Rev 6/95

Baltimore,

Box 68760, P.O.

Division of Vital Records,

Physician:

or Attending

death.

efter death Director:

24 hours e Funeral C Hospital

within 2 To the

10

compietely

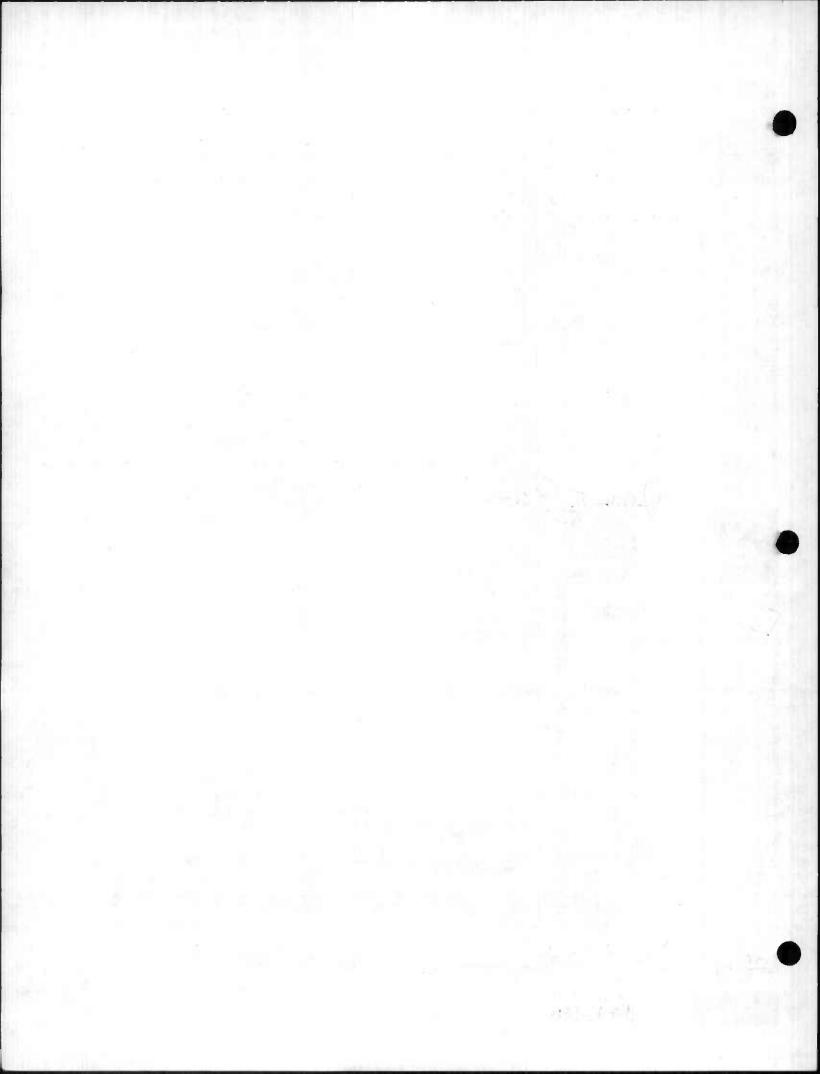
31. Dete filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

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					0	,

Fu	Physicia /Medic Examin		Decedent's Name (First, Middle, Last))					2. Date of De	Reg. No.		
Fu	/Medic								Month		3. Tima of Death	
Fu		aı ı	Zoleta Er	win					May		98 12:20 P.M	
11/45			4a. Facility Name (If not institution, give	street and number)				4b. City, Town, or	Location of Death	4c. County of		
11125			12804 Kemper Lane					Bowie		Prince	George's	
	uneral rector		5. Social Security Number 6. Se 455 26 2833 Usuel Residence of Dacadent	7. Age	(In yrs. last bir 75	Yrs. If Uni	der 1 Yea ns Deys		. (Month, Da	th y, Year)	9. Birthplace (State or Foreign Country) Plaska TX	
yland			10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
e Mary	iffed at	ctor	Maryland Prince Ge	eorge's	Bowie	2					XSYYes 2□ No	
ith th	or 28	Director	10e. Street end Number			10f.	Zip Code			10g. Citizan of Wh	nat Country?	
w di	238		12804 Kemper Lane	2			207	15		United	States	
5-0020 72 hours after death with the Manyland	natural", or items 23s or 28s-f shidical Examiner must be notified	by Funeral	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Wes Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give			cadent of pecify Cu	Hispanic Ortgin? (5 ben, Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)	14. Raca Biack, Specify:	American Indian, White, etc.	
9 Por	tura a E		15. Decedant's Edu	Year or Dates: ¿		Decedent's II	aual Oaa	mation		16h Mad at Burd	White	
T. 5	- 40	Completed	(Specify only highest grad	e completed)		Give kind of life. DO NOT	work done use retir	apation e du <i>ring</i> most of wo ed)	rking	16b. Kind of Busi	nass/industry	
d 2121 filed within Hygiene.	the	E O	Elementary/Secondary (0-12)	Coilege (1-4or 5+)		Iomemak		/		Own Ho	me	
Dd 2	other ent,	BeC	17. Fathar's Nama (First, Middla, Last)	_	1 4	TOMEMAK	CI	18. Mothar's Na	me (First, Middle,	Maiden Sumama)		
ylan buld be Mental	7 is marked othe traumatic event,	ToB	Cephas W. Jones					Ora Mae	Hatten			
faryla 2 should and Men	e me		19a. Informant's Name/Relationship (Ty	pe, Print)	19b	. Malling Addra	ass (Stree	at and Number or R	ural Route Numbe	er, City or Town, S	tate, Zip Coda)	
1 and 1 Health	OI N		Lynn Erwin Da	ughter						anicsvil	1e MD 20659	
Baltimore, permit. Pages 1 ar Department of Hea	nt: If Item 2 iry or other		20a. Method of Disposition 1 Burlat 2 Cremation 3 A 4 Donation 5 Other (Specify)	lemoval from State				aca) June 2 al Cemete			ity or Town, State re Maryland	
alti mit.	mportant: any injury ance.		21. Signature of Funeral Service Licepu		Durern	22. Name	and Addr	ess of Fecility	-		re naryrand	
m 28.	eny le	1	1 Comes & G	or me				Evans Fu			00715	
4			23a. Part. Enter the disease, or complished, or heart failure. List enty or	cations that caused th	e daath. Do r	not entar tha m	ode of dy	apolis Rd ing, such as cardia	c or respiratory ai	maryland rest,	20715 Approximete Interval Between	
Phys	sician		shock, or heart latture. Listerly or	ie cause on each line.							Interval Between Onset end Deeth	
	edical miner		Immediata Cause (Final disease or condition resulting in death)	16	/		10	· lone			1 wk.	
PE		-	Tooling III down,	į Di	e to (or as a	consequence	of):	,			Youths	
B .	ransit	Examine	_ t	n. P.C	pil.	16		1100			1-onths	
(D	4.5	Exa	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated exacts)	le to (or as a c	consequenca o	r):						
96	13											
	0.0	Medical	resulting in death) Last Dua to (or as a consequence of):									
8 3	attendir for use	and		l. ————								
. 0	the at	SC	Part II. Other significant conditions con	tributing to death but r	not resulting In	the undarlying	g cause g	iven in Part I.	23b. Dld 1	obacco use contr	ibuts to the causs of death?	
D to		by Physician/							10	Yes 2 → No 3	Probably 4 Unknown	
ecorc law requir	has been signed 2 should to	Completed								an autopsy med?	24b. Wera autopsy findings evailable prior to completion of cause of death?	
T et	page page	0							101	res 2 No	1 Yes 2 No	
clan Clan	rector, pag	Be	25. Was case referred to medical examiner?						ath (Check only o	ne)		
of Vita Physician:	al di	2	1 1 1 48 2 5 1 1 1 0	ospital:	2 ER/Out		DON		lome 5 Resid			
Jang P	funer	ton:	27. Mannar Death 1 Natural 5 Panding investigation	28a. Date of Injury (Month, Day Y	<i>(ear)</i> 28b. T	ime of njury M	28c. Inju	ork?] Yes 2 □ No	28d. Describe h	now injury occurred		
To the Hospital or Attending I within 24 hours after death.	ompletely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (- At home, fai (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital within 24 hours	Punera etely fille	edical	29a. Certifier (Check only one) Certifying Phys	Iclan: To the best of ner: On the basis of exand manner state	amination and	, daath occurra d/or investigation	d at the t	ime, data and place opinion, death occi	e, and dua to tha curred at the time,	causa(s) and mann date and place, an	er as stated. d due to the cause(s)	
the state of	omple	-	29b. Signature and Ittle of certifier	and mainter states		2	9c. Licen	se number		29d. Dete signed (Month, Day, Year)	
F 3 F	- 0		1// 1	2			1) 1	1/11.		1/1/4	P	
25	1	-	30. Name and address of person who co	moleted source of de-	th (ttom 22-) (Type Bri-t\		770)	3////	/	
00	1		A C. 12	1) (64	(maiii 238) (L D	, <	5. 00-	1 -	1300	16713	
	Stat	•	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	201		4-10	- 0-1		2677	

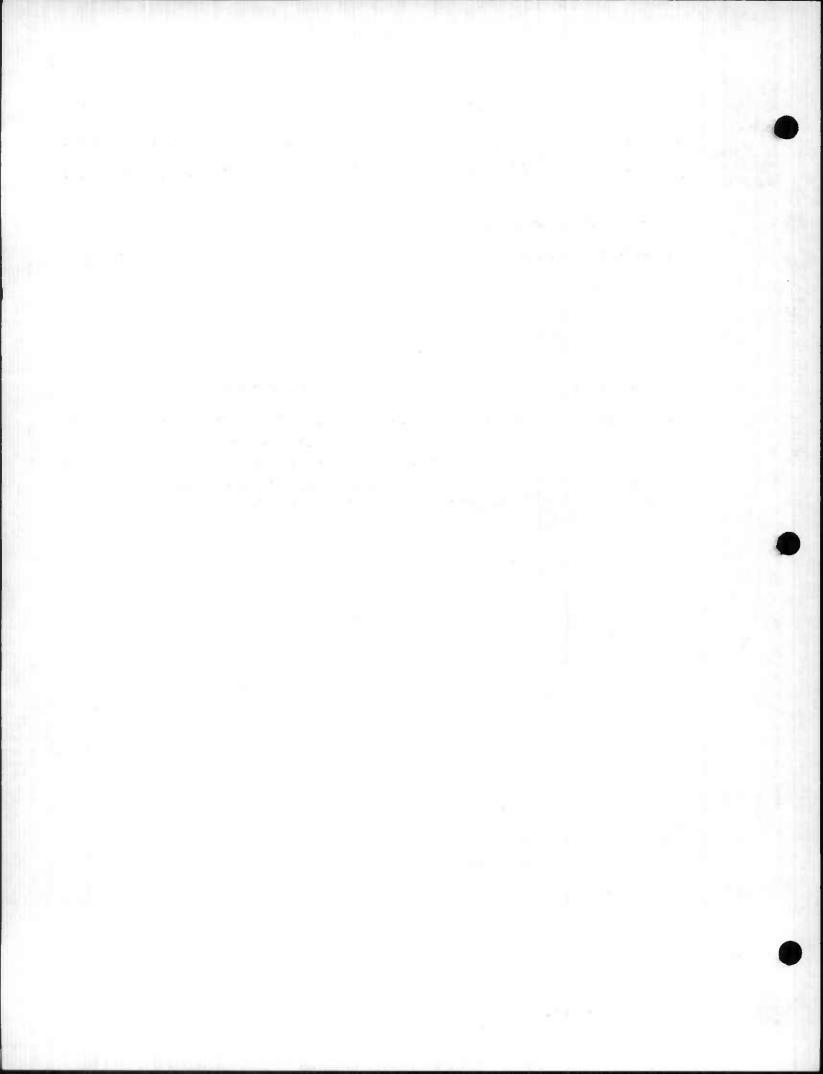


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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Janet Fisher 7:15 AM JUNE /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Doctors' Community Hospital Prince George's Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M XXF Months Hours Min. 160 26 9501 64 July 24 1933 Pennsylvania **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified as XX Yes 2 No Director Maryland Prince George's 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12800 Buckingham Drive 20715 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates; 1 Never Married 20 Married by 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade Elementery/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, me. College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Fatz Verna Orzel 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo J. Fisher Husband 12800 Buckingham Drive Bowie Maryland 20b. Place of Disposition (Neme of cometery, crematory or other place) June 5, 1998 20a. Method of Disposition 20c. Location - City or Town, State Burlai 2 Cremation 3 Removel from State Maryland Veterans Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Cheltenham Maryland 22. Name end Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Pert1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one ceuse on each the Approximate Intervel Between Physician /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last fi millale Box 68760. Physician/Medical The law requires that the death certificate signed by the a P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 Yes 2 No 1∆Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homlcide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner steted. within 2 To the I 29d. Date signed (Month, Dey, Year) R. PATEL 612/91 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 20770. Hanover 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Julia Davidson Randale JUN 0 5 1998 Registrar



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month JUNE **Physician** 1998 DOROTHY V. 9:02 AM FEINDT /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** BALTIMORE 9305 WALTHAM WOODS ROAD BALTIMORE If Under 1 Yeer 8. Date of Birth (Month, Dev. Year) 7 6 2 6 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 M F Yrs. 71 216-20-3260 MARYLAND Director Usuel Residence of Decedent with the Manyland 10a State 10b. County 10c. City. Town or Location 10d, inside City Limits 7 is marked other than "naturel", or flems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9305 WALTHAM WOODS ROAD 21234 U.S.A. Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mantal Hygiene. Important: if item 27 ie marked other there any injury or other trainment. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify p WHITE 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOME 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) unknown BERTHA ADAM KOWALCZYK 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) HENRY FEINDT/ HUSBAND 9305 WALTHAM WOODS ROAD BALTIMORE, MD.21234 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete HOLY ROSARY CEME. 6/6/98 4 ☐ Donation 5 ☐ Other (Specify) DUNDALK, MD. 21. Signature of Funerel Service Licansee 22. Name and Address of Fecility
KACZOROWSKI FUNERAL HOME Varsowick 1201 DUNDALK AVE. BALTIMORE, MD. 21222 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, abock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel SMALL CELL LUNG CARCINOMA MONTHS disease or condition resulting in deeth) Examiner Due to (or as e consequenca of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequenca of): PILE Physician/Medical Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? the á 1 Yee 2 No 3 Probably 4 Unknown signed t RONAR FAILURE p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy HIGH BLOOD PRESSUPE 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA

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Division of Vital or Attending after death. Director: Aft 24 hours Hospital

10 Certification:

27. Manner of Death

1 Neturel

2 ☐ Accident

3 Suicide

30. Neme ended

31. Dete filed (Month, Day, Year)

JUN 0 5 1998

29e. Certifier

4 Homicide

Medical To the I

State Registrar

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated. 29b. Signature and

5 Pending

investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

ss of person who completed cause of death (Item 23a) (Type, Print) 8813 WACTHAM WOODS 32. Registrar's Signature

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of

29c. License number

28c. Injury et Work?

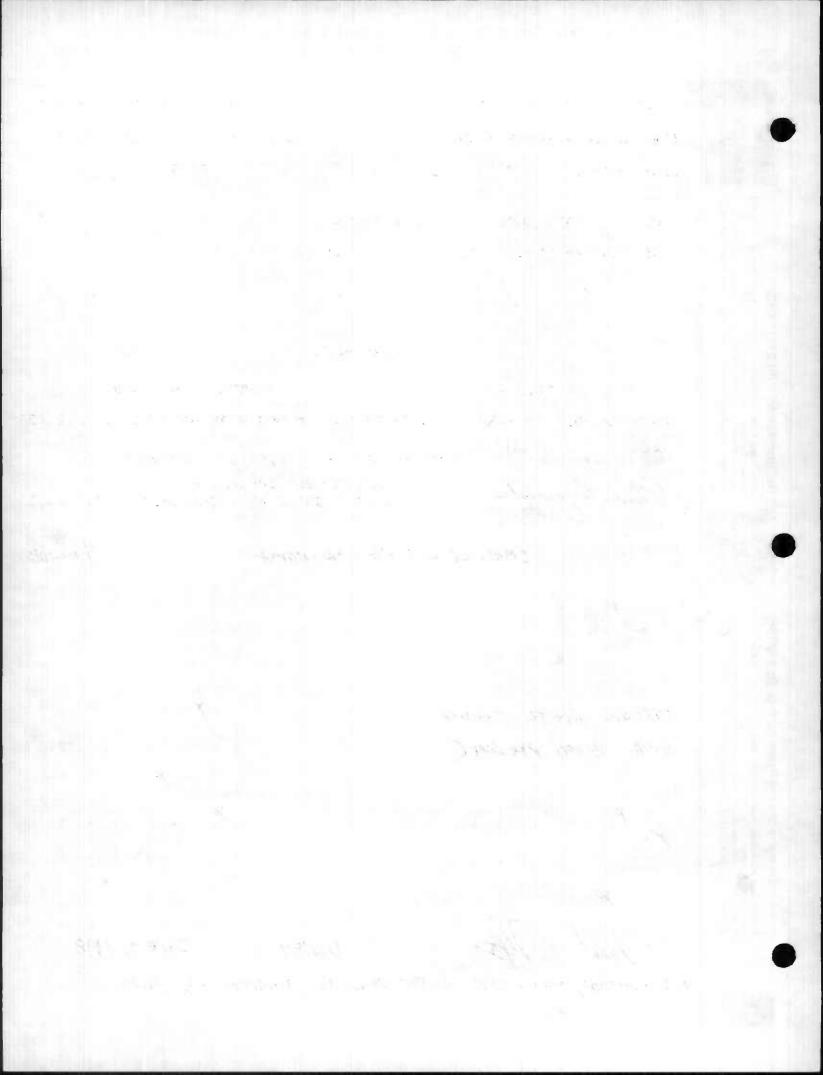
1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

RD, BANMORE, MD

28d. Describe how Injury occurred



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2 Date of Death 3. Time of Death May 28 Nathalie F. Fyock 1998 10:54AM 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) 1□ M 2⊠ F Months Davs Hours Yrs. 84 June 14, 1913 Baltimore.Md. 225-07-5058 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Harford Joppa 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 2309 Dunwood Lane U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Payroll Clerk Baltimore Co. Public Schools n/a 18. Mother's Name (First, Middle, Meiden Sumeme) Mary Byrus 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2309 Dunwood Lane (Husband) Joppa, Maryland 21085 20c. Location - City or Town, State

Elementary/Secondary (0-12) 10 yrs. 17. Father's Name (First, Middle, Lest) James Fitzgerald 19a. Informant's Name/Relationship (Type, Print) Donald P. Fyock 20b. Placa of Disposition (Name of cametery, cremetory or other piece) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Grds. 6/1/98 Fallston, Md. 21047 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility
E. F. Lassahn Funeral Home

11750 Belair Road 11750 Belair Road Kingsvi cutions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, the cause on each line. Kingsville, Maryland 21087

Immediete Ceuse (Final disease or condition resulting In death)

Approximate Interval Between Onset and Deeth

Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

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Examiner

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Department Inportant: If any Injury or

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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo

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page 2 should

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Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

6 Could not be determined

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24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes an autopsy performed?

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1 ☐ Yes 2 No

1 ☐ Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2N No

Hospital: 1 Munpatient 2 ☐ ER/Outpatlent 3 ☐ DOA

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 - Homicide

Date of Injury (Month, Dey Year) 5 Pending investigation

28b. Time of Injury

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

29g, Date signed (Month, Day, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

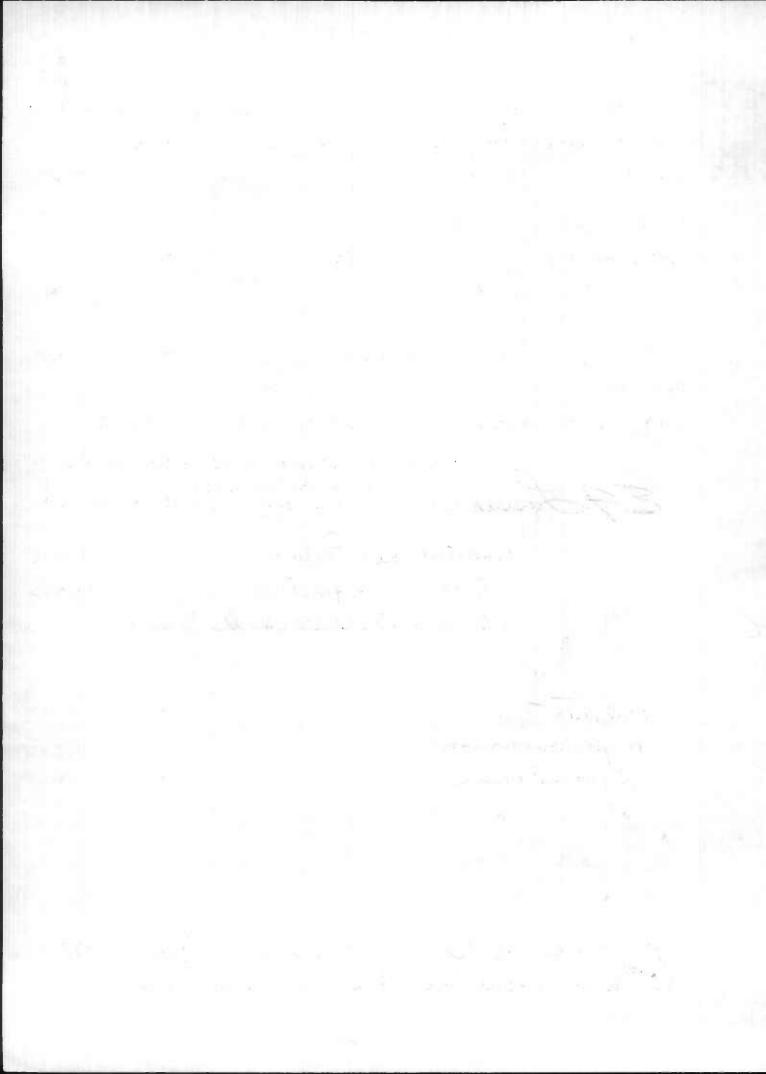
29b. Signature end title of cartifie

30. Neme and address of person

Hickory 31. Date filed (Month, Dey, Year) State Registrar JUN 0 5 1998

Bei 32. Registrer's Signature

ause of deeth (Item 23e) (Type, Pri



				Certificate of	of Death	R	eg. No.	. ,			
	1. Decedent's Name (First, Middle	th Day	3. Time of Death								
Physician /Medical	Charles Howa	rd Gro	ve			June 4,	1998	3:15pm			
Examiner	4a Facility Name (If not institution	n, give street and num	nber)		4b. City, Town, or L	ocation of Death	4c. County				
	301 Orchard Roa			W11	Edgewater	r	Anne	Arundel			
Funeral Director	5. Social Security Number 579–01–6713	6. Sex 1½ M 2□ F	7. Age (In yrs. last birt 78	hday) If Under 1 Ye Months Da		8. Date of Birth (Month, Day May 26,	1920	9. Birthplace (State or Foreig Country) Illinois			
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits			
Ba-f ehow	MD Anne	Arundel	Edgewa	ter				1 ☐ Yes 2€ No			
offer deeth with the Marer ferms 23s or 28s-f entre must be norther Funeral Director	301 Orchard Ro	ad		10f. Zip Cod 2103	37		0g. Citizen of V				
rail, o	11. Merital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Fo		13. Was Decedent of If Yes, specify C	of Hispenic Origin? (S cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	Blad	er - American Indian, ck, White, etc. v: White			
	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	t's Education st grade completed) College (1	-4or 5+)	Decedent's Usual Oc (Give kind of work do life. DO NOT use rel NSPECTOR,	ne during most of wor tired)						
should be filed within and Mentel Hygiene. marked other than matic event, the Mentel To Be Comp	12 17. Father's Name (First, Middle, Charles Theodor			nepector,	18. Mother's Ner	ne (First, Middle, Katrina)	Maiden Suman				
th and Men th and Men 7 ie marke traumatic	19a. Informent's Name/Reletions Josephine Grove				eet and Number or Ru Road, Edge	ıral Route Numbe	r, City or Town,				
Department of Health Department of Health mportant: if frem 27 any injury or other tr anges.	20a. Method of Disposition	• 🗆	remeter	Disposition (Name of	place)	Date	20c. Location	City or Town, State			
Peges ment of h ant: if ite ury or of	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			Crematory		/5/98	Baltim	ore, MD			
permit. Pege Department of Important: If any injury or once.	21. Signature of Funeral Service	11	1/200	22. Name and Ad Hardestv	Funeral He	ome, P.A.					
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Physician	shock, or heart failure. List	only one cause on e	ach line,	of other trie mode of		or respiratory an	031,	Approximate Interval Between Onset and Death			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Myocard() Infavotion Due to (or es a consequence of):							Function			
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rinicate be axecuted by physician and es the bunal-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as a o	consequence of):	Jensis			Yrs			
	thet limiteted events resulting in death) Last Due to (or as a consequence of):										
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this certificata ral director, pag.	25. Was case referred to medica				26. Place of Dea	ath (Check only o					
00	examiner?	Hospital: 1 🗆 I	npatient 2 ER/Ou	tpatient 3 DOA	Other: 4 Nursing F	lome 5 mesid	ence 6 Ott	ner (Specify)			
Attending Provides to death. Sector: After the by the funeral iffication:	27. Menner of Death 1	gation			njury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	28d. Describe how Injury occurred				
rs after death. al Director: After ted in by the funeral Certification:	3 Suicide 6 Could 4 Homicide determ	Ined 288. Place	of Injury - At home, faing, etc. (Specify)	rm, street, factory, offi	ice	28f. Location (S City or Tow	treet and Num. n, State)	ber or Rural Route Number,			
which 24 hours after death. To the Funeral Director: After this completally filled in by the funeral Medical Certification:			best of my knowledge sia of examination and ner stated.					anner as stated. and due to the cause(s)			
To the complete	29b. Signature and title of certifie	Farm	1	29c. Lic	ense number	5	29d. Date signe	od (Month, Day, Year)			
10	30. Name and address of person 31. Date filed (Month, Day, Year)	NiFrie	e of death (Item 23a) (20 equistrar's Signature	Type, Print) Ig	ely Ar	Bu	nopuli	5, w/21401			

State Registrar

JUN 0 5 1998

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Dey Dewey Franklin Gordon May 28 1998 7:40 P.M. 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Larkin Chase Nursing Center Prince George's Bowie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) 9. Birthplace (State or Foreign Deys 180 M 2□ F Months Hours Min. 570 05 3018 89 May 15 1909 North Carolina Usuel Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland Bowie 1⊠ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14216 Pleasant View Drive 20720 United States 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. ☐ Yes 🏋 🖾 No Yes. Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorcad Year or Dates: White 16e. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Security Officer Security 17, Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Bascomb Gordon Lula P. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Michele Cirrincione Daughter 3938 Sunflower Circle Mitchellville MD. 20721 20b. Placa of Disposition (Name of cametery, crematory or other placa) June 2, 1998 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Cedar Hill Cemetery Suitland Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 21. Signature of Funeral Service License 16000 Annapolis Rd. Bowie Maryland 20715 2024 corpolications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each line. Intervel Between Onset and Deeth FAILURE Immediate Cause (Finel diseese or condition resulting in death)

Physician /Medical **Examiner**

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Pages 1 and 2 should be filed within 72 hours efter near of Health end Mental Hygiene.
Int: If Itam 27 is marked other than "natural", or its Iry or other traumatic event, my Modical Examina

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Baltimore, Maryland

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Division of Vital Attending Physician:

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Due to (or es a consequença of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. STROKE Cardiac-ante

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 SUnknown

24e. Wes en eutopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 ☐ Yes 2 Mio

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Sulursing Home 5 Residence 8 Other (Specify)										
Other:	4 Wursing Home	5 Residence	8 Other (Specify)							

25.	Wes case examiner?	to	medical
	1 Yes		

27. Manner of Death 1 Maturel 2 Accident 5 Pending investigation

6 Could not be determined

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Date of Injury (Month, Day Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a, Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end menner as stated. ✓ Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and menner stated.

29b. Slaneture end title of certifier

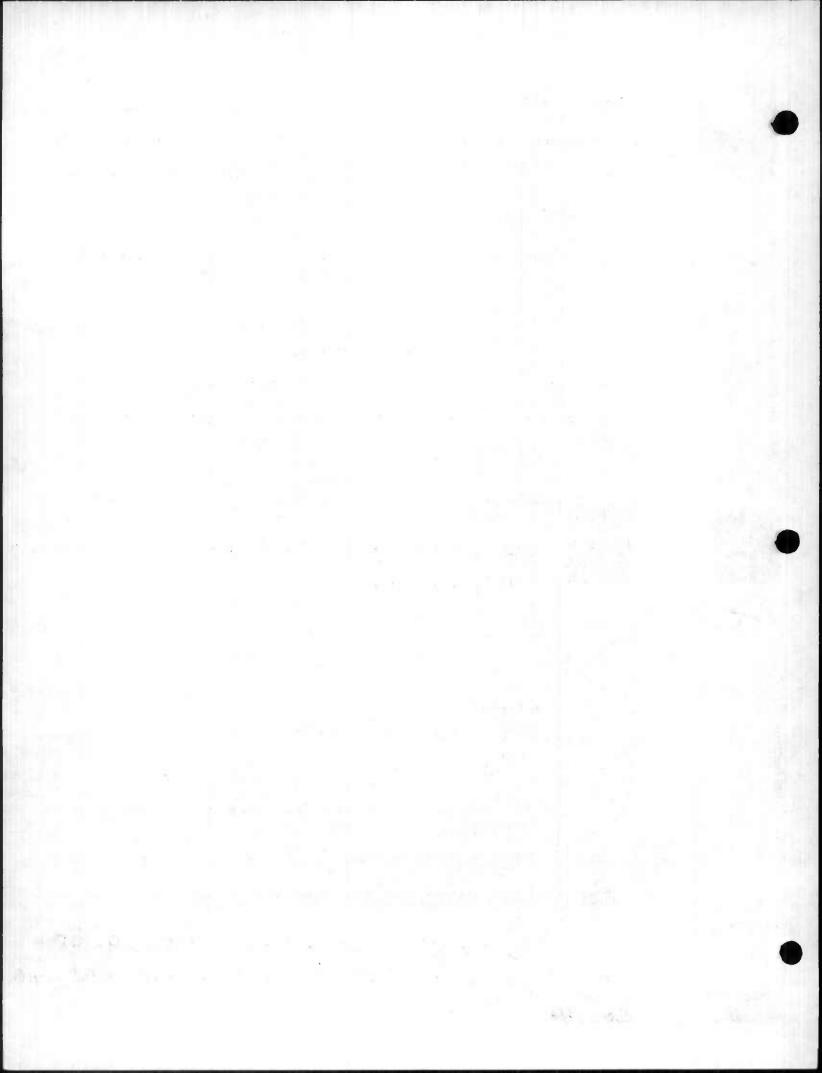
29c. License number -34525 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 4000 - Mitchell ville Road; # 220. Boure-120716. - MAO mo. 31. Dete filed (Month, 32. Registrer's Signature

State Registrar

Julia Davidson

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #7.8 Per FH Film G760 6-5-98RC 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** -rank Gerard 27 1998 Ma 04 55 AM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** GenBurnie Mariner Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 700-03-6600 87 Yrs. **Director** Simpson, W. Virginia Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12020 Brooknoll Road 21087 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Mamied Specify: White 1 ☐ Yes 2 No Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) 5yrs. Manufacturer n/a Self-Employed 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sebastian Gerard Mary Guzzi 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Frank J.Gerard (Son) 501 Heath Ave. North Linthicum, Md. 21090 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/30/98 Fallston, Maryland 21047 Highview_Cemetery 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Approximate interval Between Onset and Death **Physician** - ACUTE ISCHEMIC EVENT. /Medicai Immediate Cause (Final 5 MINUTES disease or condition resulting in death) **Examiner** Physician/Medical Examiner CEREBIOVAS CULAR DISCASE° Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last GENGRALIZED ALREMOSCLEKOST Due to (or as a consequence of Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? HYPERTENSION 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) 2

P.O. Box 68760 The law requires that the death certificate Records, 8 paga 2 of Vital or Attending Physician: After Division within 24 hours after death.
To the Funeral Director: All completaly filled in by the fu

must be notified at

Herne

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the Medical

Hygiene.

i. Pagas 1 and 2 should be filed w tment of Haalth and Mantal Hygier tant: if item 27 is marked other th jury or other treumatic avant, the

Department of Important: If any Injury or

with

filed within 72 hours after

21215-0020

Baltimore, Maryland

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending Investigation 2 Accident

28d. Describe how Injury occurred

1 Tes 2 No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier (Check only one)

leiden M.D.

29c. License number D-22609 29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBEN REIDER M.D. 7445 FURNACE BRANCH Rd 6/ENBURNIE Md 21060

State Registrar

Certification:

Medical

3 Suicide

4 Homlcide

29b. Signeture and title of certified

31. Date filed (Month, Day, Year) JUN 0 5 1998

6 Could not be determined

Hospital

the th

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryla

and /	Department of Health and	Mental	Hygiene
	Certificate of Death		Reg. No

2. Date of Deeth

21,

4c. County of Death Harford

10g. Citizen of What Country?

3. Time of Death

1:35 PM.

Birthplace (Stata or Foraign Country)

10d. Inside City Limits

1 Yes 2 No

Russia

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last)

Funeral

Director the Maryland 7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, the Medical Examiner must be notified at death

Pages 1 and 2 should be filed within 72 hours after of the fold and Mental Hygiene. Int: If item 27 is marked other than "natural", or item other any injury or o

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physic 8 990 Division of Vital Records, P.O. 8 ā bengis d be det Pass **page 2** certificate director ä Ather i or Attend after deat Director:

4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 601 CORNELL ST. #402 ABERDEEN

If Undar 1 Yaar | If Under 24 Hrs. | 8. Date of Birth
Months Days | Hours | Min. | (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Months Days 1□ M 25√F 136-36-7486 55 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 601 Cornell St., Apt. 402 21001 Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) Waitress 17. Fether's Neme (First, Middle, Last) Theodore Polowetz 19a. Informant's Name/Relationship (Type, Print) Thomas C. Geib/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 1 ☐ Burial 2 X Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/5/98 21. Signature of Funeral Service Licent 22. Nama and Addrass of Facility Immediate Cause (Final Fatty Luce disaase or condition resulting in death) Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. À Completed Be 25. Was case referred to medical exeminer? 2 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury et Work? 28b. Time of Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 ☐ Could not be determined 3 Suicida 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 29a. Certifier

Marie P. Hickman

UNK. 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, White, etc. White 16b. Kind of Business/Industry Hotel Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) Agafia UNK. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 601 Cornell St. Apt. 402 Aberdeen, MD 21101 20c. Location - City or Town, State Baltimore, MD Cremation Society of Maryland, Inc.

Edward A. Gregorchik

299 Frederick Rd. Baltimore, MD 21228

23a. Parti. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Intarval Between Onset and Death 23b. Did tobacco usa contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 □ No 16 Yes 2 No 26. Place of Death (Chack only one) Other: 4 ☐ Nursing Homa 5 ☒ Residence 6 ☐ Other (Specify) 28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian Wonald O.C.M.E. MAY 22, 1998 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 HONALD G. WRIGHT MD 31. Dete filed (Month, Dey, Year) JUN 0 5 1998 32. Registrar's Signeture

State Registrar

Julia Davidsor Mandalle

A 24 hours Hospital

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The second second - Hay Fred Assess X Non- of St. Warush Hill Dange chierate

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month **Physician** 8 15 AM Floyd Haraina 98 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore City Veterans Hospital Baltimore Baltimore H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | AUG 21, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 12XM 2□ F Months 220 14 4796 Yrs. Director Maryland Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inalde City Limits item 27 te marked other than "natural", or itema 23a or 28a-f eho other treumetic event, the Medical Examiner must be notified al 1X Yes 2 No N/A MD Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4105 Barrington Road 21207 USA 1 2 should be filed within 72 hours efter death it and Mental Hygiene. Ie marked other than "natural" or famm non-Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Eiementary/Secondery (0-12) College (1-4or 5+) Self-employed Transportation 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Floyd Harding, Sr. Grace Young 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2.
Department of Health ar
Important: If item 27 ie
eny Injury or other treu Susie Ann Harding / Wife 4105 Barrington Road Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 06/03/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Edward A. Gregorchik Cremation Society of MD, Inc. 299 Frederick Rd. Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** tmmediate Ceuse (Final disease or condition resulting in death) /Medicai uremia days **Examiner** Due to (or es e consequence of): Physician/Medical Examiner failure (acute) renal Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): congestive heart Due to (or as a consequence of) resulting In death) Last USE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco uas contributs to the cause of death? 1 No 3 Probably 4 Unknown of Vital Records, à 99 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes So No 1 TYes 2 No 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospitel: 1- Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 10 1 Yes 20 No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: al or Attending P after deeth. 5 Pending Investigation **FBNaturel** 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homleide Hospital 24 hours 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier MD 6/2/98 ran P11739 unco 30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

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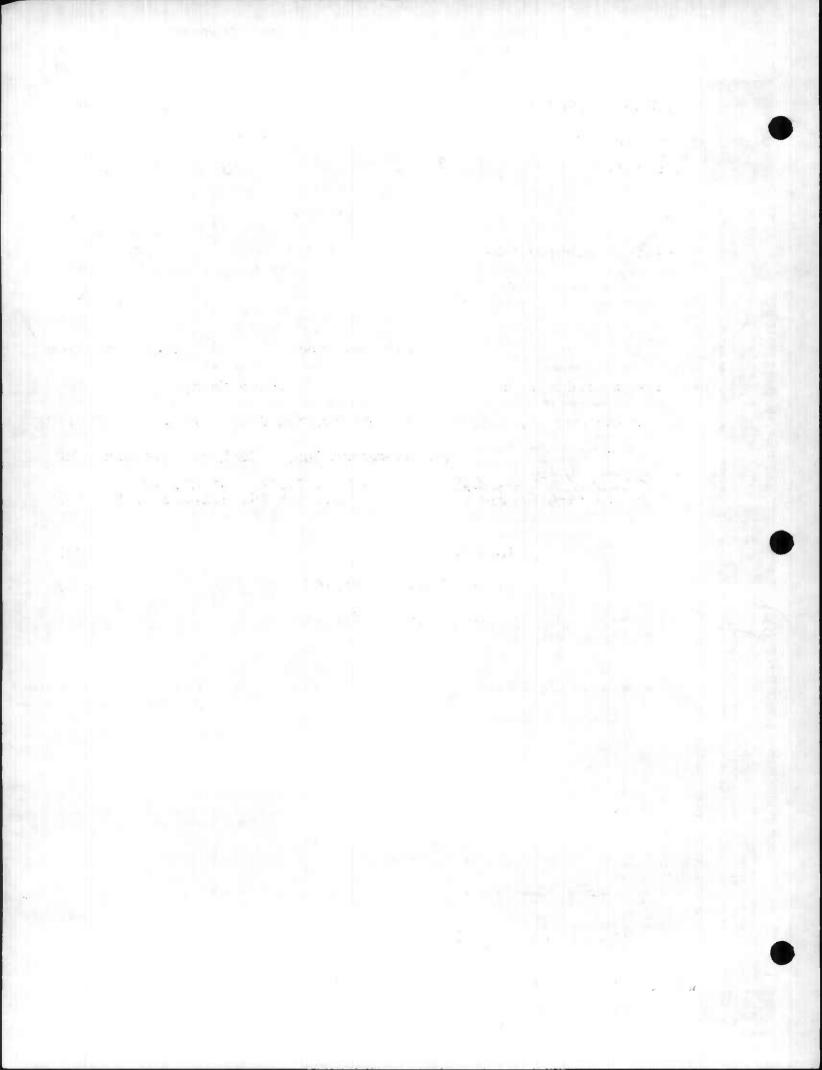
Alicia Braun, MD
31. Date filed (Month Pay, Year)
398

10 S. Greene St., Baltimore MD, 21201
32. Registro's Signature

Sina Savidson-Randelle

Registrar

State



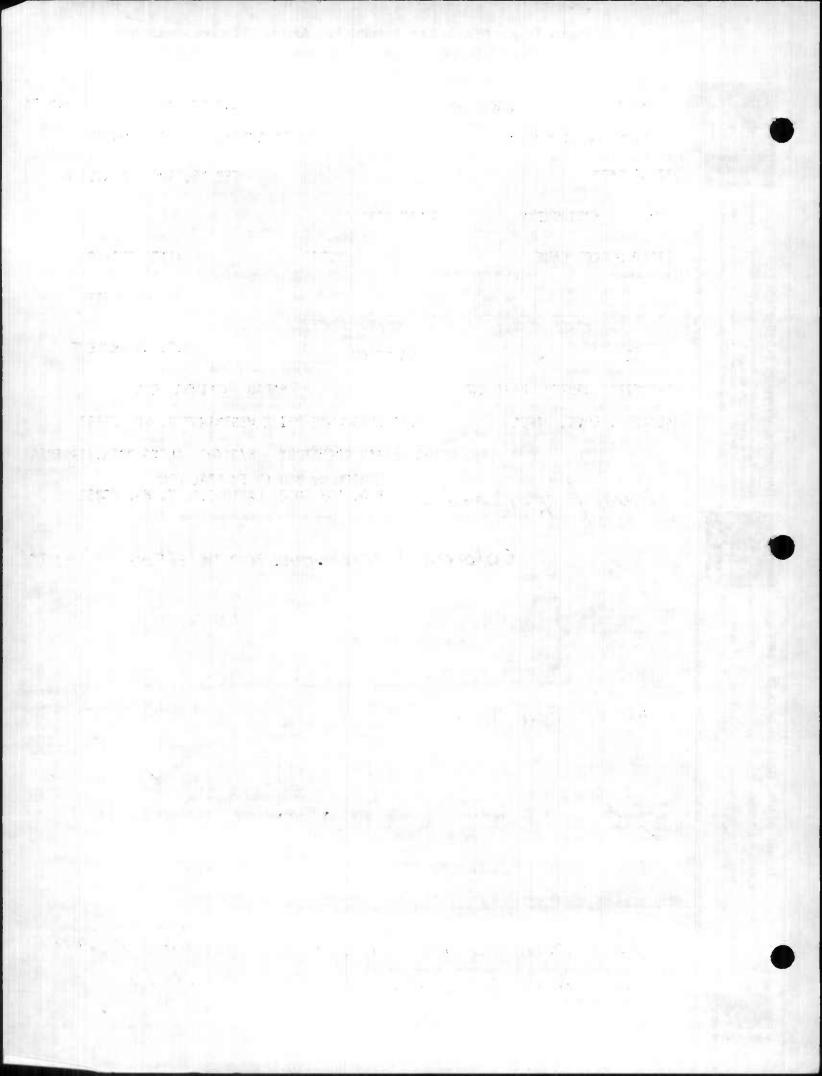
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death MAY" 30,1998 **Physician** 12:45 PM **FDITH** Α. HAVII AND /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner SANDY SPRING MONTGOMERY FRIENDS NURSING HOME 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Dete of Birth **Funeral** Months Deys Hours Min 1 M 2 F Yrs. 577 05 7673 Director 94 FEB. 25, 1904 MARYLAND Usuel Residence of Decedent with the Meryland 10a Stele 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examinar must be notified at MD. **MONTGOMERY** SANDY SPRING 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17340 QUAKER LANE 20860 UNITED STATES 2 should be filed within 72 hours after death in and Mental Hygiene. Is marked other than "natural", or items 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) completed) Elementery/Secondery (0-12) College (1-4or 5+) U.S. GOVERNMENT SECRETARY 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) **EBENEZER** WANZER HAVII AND SARAH MELINDA EDGE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If them 27 is ALICE H. LOVE, NIECE 1313 GUADELUPE DRIVE, WESTMINSTER, MD. 21157 20b. Pleca of Disposition (Neme of 20c. Location - City or Town, State 20e. Method of Disposition METROPOLITAN CREMATORY 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removei from Stele ŏ 5/31/98 ALEXANDRIA, VIRGINIA 4 ☐ Donetlon 5 ☐ Other (Specify) 22 MHR INCLADO SS OF ARBER FUNERAL HOME 21. Signeture of Funerel Service License P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical tmmediate Ceuse (Finel disease or condition resulting in deeth) caranoma with metastasis Examiner Due to (or es e consequence of) Examiner ettending physician and for use as the burial-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enler Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 23b. Did tobacco uss contributa to the causs of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Fibrillation by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? page 2 has 2 No 1 Yes 2 No certificate 1 Yes or Attending Physician: Be 25. Wes case referred to medical 28. Piece of Deeth (Check only one) Hospital: 3 DOA Other: 4 Desirang Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpetient After this 28e. Dete of injury (Month, Dey Year) luneral 28d. Describe how injury occurred 27. Menne of Deeth 28h Time of 28c. injury et Work? Certification: 1 Neturel 5 Pending 24 hours after death. Funeral Director: Af 1 Tes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 🗜 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner es stated. Medical 2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleas, end due to the cause(s) end menner steted. (Check only one) within 2. To the 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number 30,1998 physician

Olney,

MD 20832

State Registrar 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #26 Per MD Film G760 6-5-98RC Certificate of Death 1. Decedant's Nema (First, Middia, Last) 2. Data of Death M A Wonth **Physician** 1998 21 VIOLA M. HARRELL 11:30 m /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** 10 Maxwell Road Middle River Baltimore | If Under 1 Yeer | If Under 24 Hrs. | 6. Deta of Birth (Month, Day, Year) | Min. | May 25, 1912 5. Sociel Sacurity Number 9. Birthplace (Stata or Foreign Country) North Caroli 7. Age (In yrs. last birthday) 1 M 2 XF 218-38-3858 Yrs. 85 Carolina Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. Baltimore Middle River 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 12 South RandolphRoad USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Rece - American Indien, Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Datas: 1 ☐ Nevar Married 2 ☐ Merried White 1 Yas 2X No Specify: à 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Housewife own home 8th 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Sterlin McKinney Lela Childress 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1033 Foxridge Lane Balitmore Md. Beverly Schepf/daughter 21221 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata tX Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) HollyHillCemetery 5/23/98 Baltimore Md. 21. Signature of Funerel Service Licenses 22. Neme end Addrass of Facility Connelly Funeral Home of Essex 300 Mace AVe. Baltimore Md. 21221 Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximete Intarval Between Onset and Death Immediata Causa (Final disease or condition resulting in daath) Due to (or as a consequence of). Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Disease or Injury that initiated evants rasulting in death) Last Physician/Medical Due to fores a o Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed 1 Tyas 1 ☐ Yes 2 ☐ No 8 25. Wes casa rafarred to medical 26. Placa of Death (Check only ona) DAUGHTER'S Other: 4 Nursing Homa 5 Pesidence 6 Dother (Specify/RESIDENCE 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Funeral

Director

tem 27 le marked other than "natural", or items 23a or 28s-f show other treumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 29a or any injury or other treumatic event, the Medical Experiment mass to example.

Baltimore, Maryland 21215-0020

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P.O. Box 687

Records,

Division of Vital

2

27. Mannar of Death

1 Natural

2 Accidant

3 Suicida

29a. Certifier

4 Homicida

29b. Signature and titia of cartifier

JUN 0 5 1998

certificate After this To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After

Medical Certification: And Director: Africation of the distance of th npletely

> State Registrar

30. Nema and addrass of person who complated causa of death (Itam 23a) (Type, Pript) Rombro maruin 31. Data filed (Month, Day, Year)

5 Panding invastigation

6 Could not be

32. Registrar's Signatura Fulle Savidson

28b. Tima of

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28a. Data of Injury (Month, Day Year)

end menner stet

0

28d. Dascribe how injury occurred

26f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

28c. Injury at Work?

12 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s)

29c. Licansa number

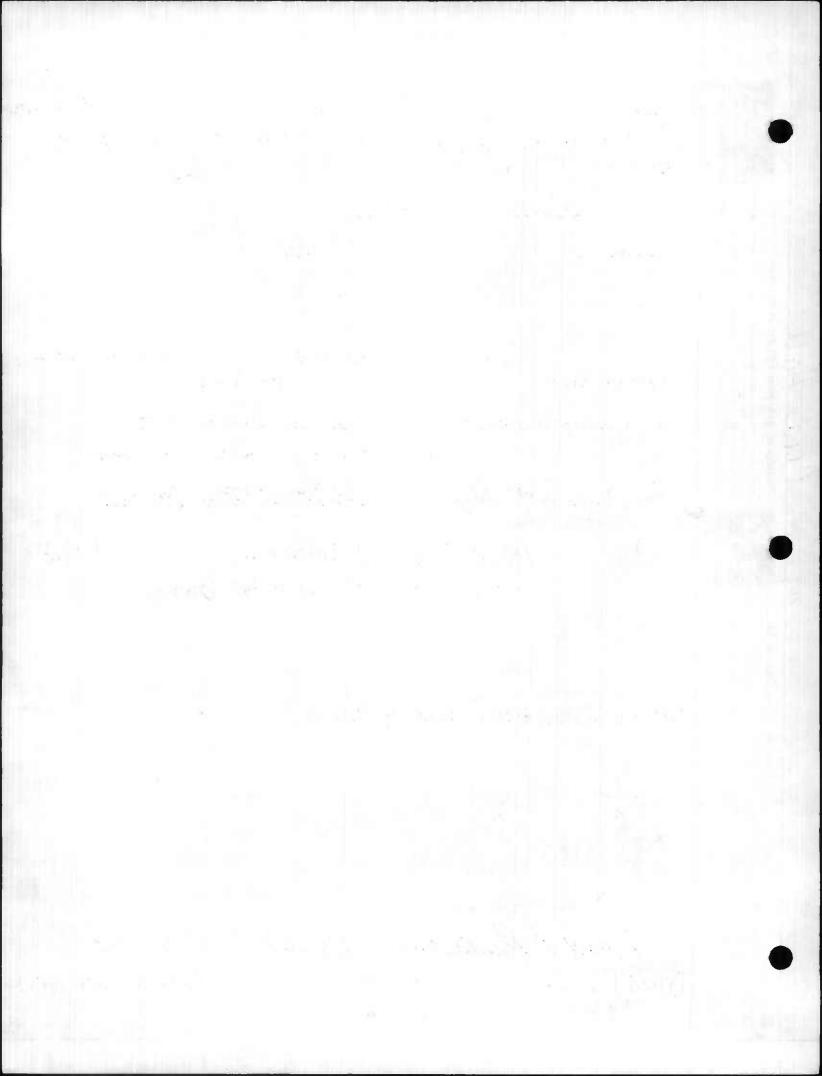
1 Yas 2 No

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** line Hall Cora /Medical o of Death 4a Facility Name (If not institution, give street and numb Examiner f Under 24 Hrs. Social Security Number 238-30-9130 (In yes, last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF 74 Director 6-18-23 NC Usual Residence of Decedent 10c City Town or Location 10d Inside City Limits 10a State 10b County Md Baltimore Middle River 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be r 30 Gyro Dr. 21220 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No It Yes, Give A Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white À 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. Transp. 8 0 Bus Attendant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Matthews Mary Kreager Lo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Neme/Relationship (Type, Print) Pages 1 and 2 Department of Health Important: If Item 27 JoAnn Livingston/daughter 4131 Lincoln Ave. Baltimore, MD 21236 20b. Place of Disposition (Name of comptery, crematory or other place) Holly Hill Memorial 20c. Location - City or Town, State 20e. Method of Disposition 17 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 6-5-98 Middle River, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD enise tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset end Death 23a. Part1. Enter the disease, or complications shock, or heart tailure. List only one **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence ot): The law requires that the death certificate be exect physician sthe burial Division of Vital Records. P.O. Box 68760. Physician/Medicai Due to (or as a consequenca ot): 88 USB ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 To Yes 2 No 3 Probably 4 Unknown signed l þ 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate Hospital or Attending Physician: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of After 1 Natural 2 Accident 5 Pending investigation after death. Director: Aft 1 Yes 2 No 3 Suicide 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 219-07-5718 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month FRANCT NUTH 16 1998 TUNE 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore City Baltimore City 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 27, 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) XXXM 2 F Months Days Hours 219-07-5718 80 Yrs Maryland Usual Rasidanca of Decedant 10e State 10b. Count 10c. City, Town or Location 10d. Insida City Limits Baltimore City Maryland Baltimore City Yas 2 No 10e. Street and Numbar 10f. Zip Coda 10g, Citizan of What Country? 2719 Berwick Avenue 21234 USA 12. Wes Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11 Marital Status 14. Race - American Indian, Black White atc XXXYas 2 NoWW]]
If Yas, Giva
Yaar or Datas: 1 Nevar Married XX Marriad 1 ☐ Yas 2√XNo Specify: White 3 ☐ Widowad 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Machinist Ward Machinery 10 yrs. N/A 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Joseph Hinke Matilda Puls 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Irene B. Hinke 2719 Beriwck Ave. Baltimore, Md. 21234 20b. Place of Disposition (Nama of cametary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Deta VS Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) St. John's Luth.Ch. Cem, 6-3-98 Baltimore, Md. 21. Signatura of Funaral Service Licensas 22. Nama and Addrass of Fecility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disaasa or condition rasulting in daath) MAYO (APDIAL TNFARCTION Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequenca of) Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy 1 2KYas 2 □ No 1 Yas 28 No 25. Was casa rafarrad to medical 26. Placa of Daath (Check only ona) Hospital: 1 ☑ tnpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be datarminad 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Cartifiar 1 Cartifying Phyalcian: To tha bast of my knowledga, daath occurrad at tha tima, date end placa, and dua to the causa(s) and mannar as stated. 2 Medical Examinar: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Records, P.O. Box 68760 Hospital or Attanding Physician: The law requires that the death certificate 2d hours effect death.

Funeral Director: After this certificate hes been signed by the attending play steely filled in by the funeral director, page 2 should be detached for use as the Division of Vital a Funeral L

Physician

/Medical

Director

Funeral

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Examiner

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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Health end Menlel Hygiene.
Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinet must be not red.

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Certification:

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Baltimore, Maryland 21215-0020

within 2 To the

> State Registrar

FADI 31. Date filad (Month, Day, Year) JUN 0 5 1998

29b. Signatura and titla of certifiar

EL-MERHI

5601

29c. License number

1998

29d. Data signed (Month, Dey, Yaer)

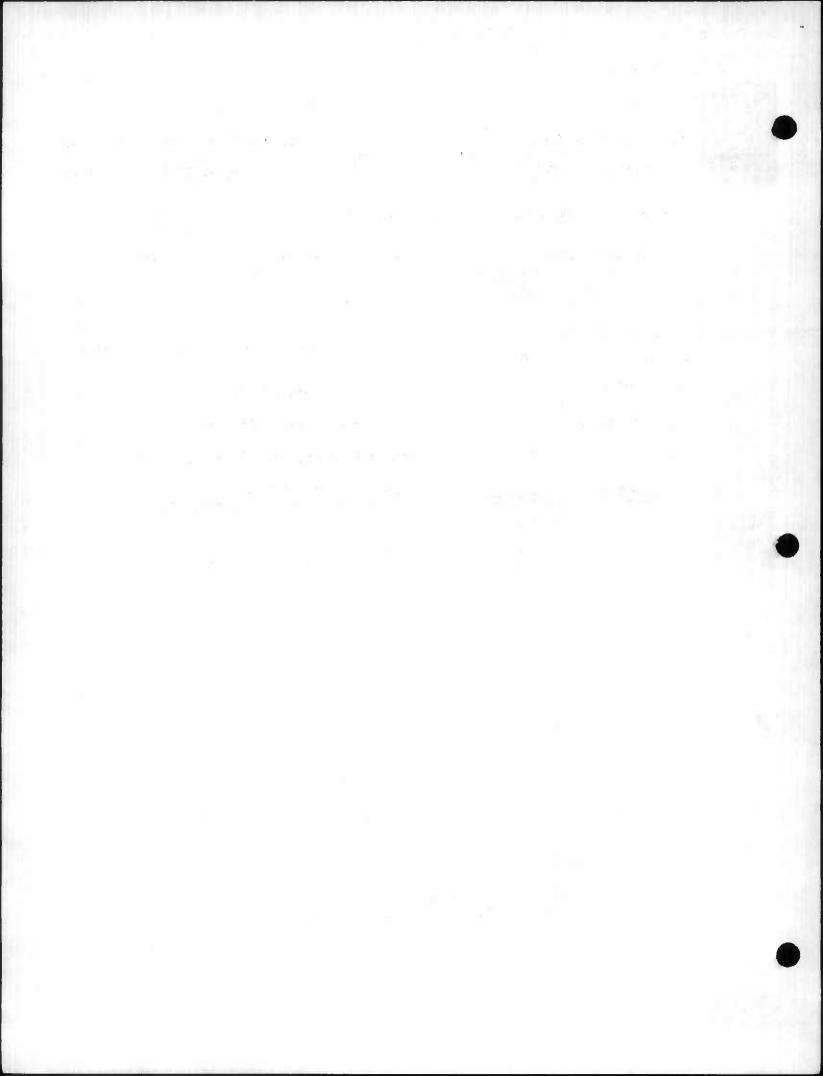
30. Nama end addrass of person who complated causa of daath (Itam 23a) (Typa, Print)

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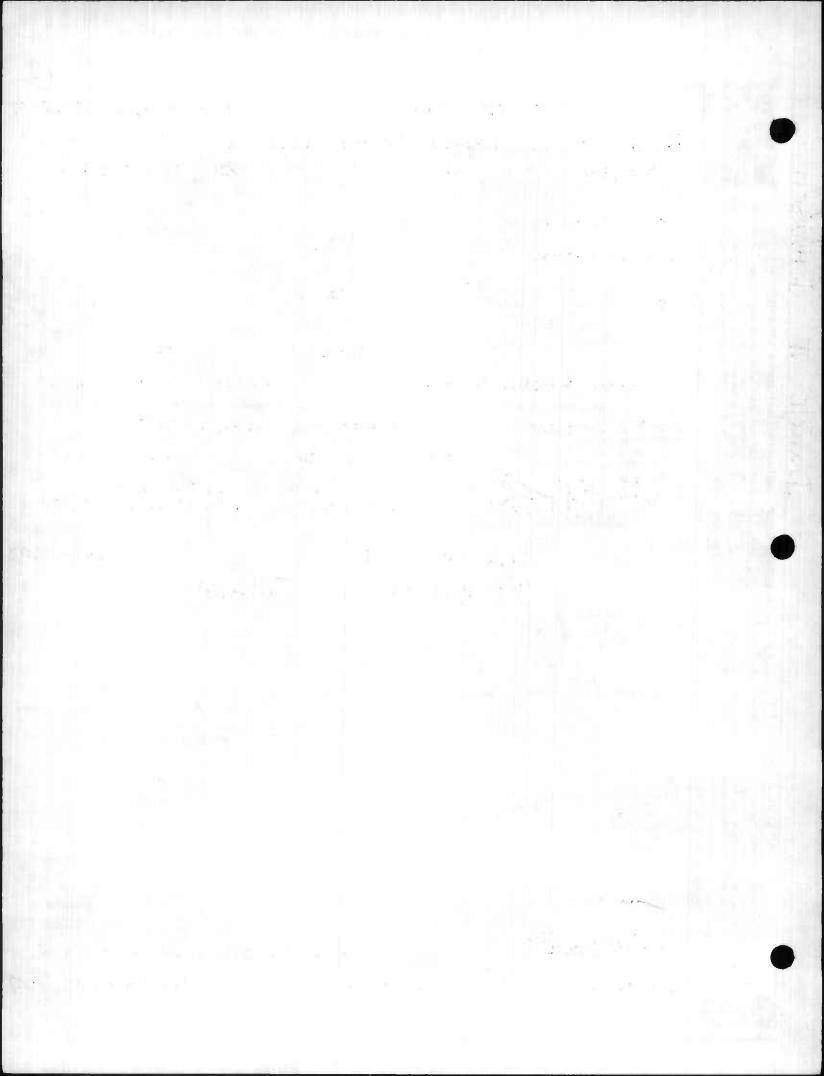
Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** 10:45 P.M Darce Jayne Johnson June /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Rosedale Franklin Square Hospita enter Himore if Under 24 Hrs. 8. Date of Birth (Month Day, Year) DEC 27, 1921 If Under 1 Year 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 9. Birthplece (State or Foreign **Funeral** Maryland Months Days 1□ M 25 F 76 212-74-1674 Director Usuel Residence of Decedent of 2 should be filed within 72 hours efter deeth with the Meryland thand Mental Hyglene. 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, pr. 285 of 18 ment be northed at traumstic event, pr. 285 of 18 ment be northed at 10a Stete 10h County 10c. City. Town or Location 10d, inside City Limits 1 ☐ Yes 🌪 ☐ No Director MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21221 3 Hartman Avenue Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerlo Rican, etc.) 14. Race - American Indien. 11. Meritel Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: ρ White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuai Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) Never Worked 18. Mother's Neme (First, Middle, Malden Surneme) 17. Father's Neme (First, Middle, Last) Pages 1 end 2 should be finent of Heelth and Mental I Elmer Hamilton Johnson Sophia Isabelle Colburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informent's Neme/Reletionship (Type, Print) 3 Hartman Ave. Essex, MD 21221 Joseph F. Kreipl/Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriei 2 X Cremetion 3 ☐ Removei from Stete Important: If it any injury or Metro Crematory, Inc. 6/5/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Si 22. Name end Address of Fecility Edu Cremation Society of Maryland, Inc. Edward A 299 Frederick Rd. Balti Pert. Enter the disease or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 299 Frederick Rd. Baltimore, MD 21228 **Physician** 6 P.M. -1045PM /Medical Immediete Ceuse (Finei diseese or condition resulting in deeth) Examiner Failure Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Physician/Medical Due to (or es a consequence of): Division of Vital Records, P.O. Box signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 XYES 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy Completed irector, page 2 1 ☐ Yes 2 ☑ No 1 □ Yes 2 □ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 70 1 Impatient 2 □ ER/Outpatient 3 □ DOA this 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. injury at Work? 28e. Date of Injury (Month, Day Year) 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) Direc 4 Homloide in 24 hours afte the Funeral Dir mpletely filled in Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) and menner as steted. 2 Madical Examiner: On the bests of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end menner stated. 29e. Certifier Medicai To the I To the I complet 29d. Date signed (Month, Dey, Year) 29b. Signety and title of cartifier 29c. License number 338 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) 9000 Franklin Square Drive Baltimore, Md 21237 Ro MeRino 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

State Registrar

JUN 051998

Auria Davidson

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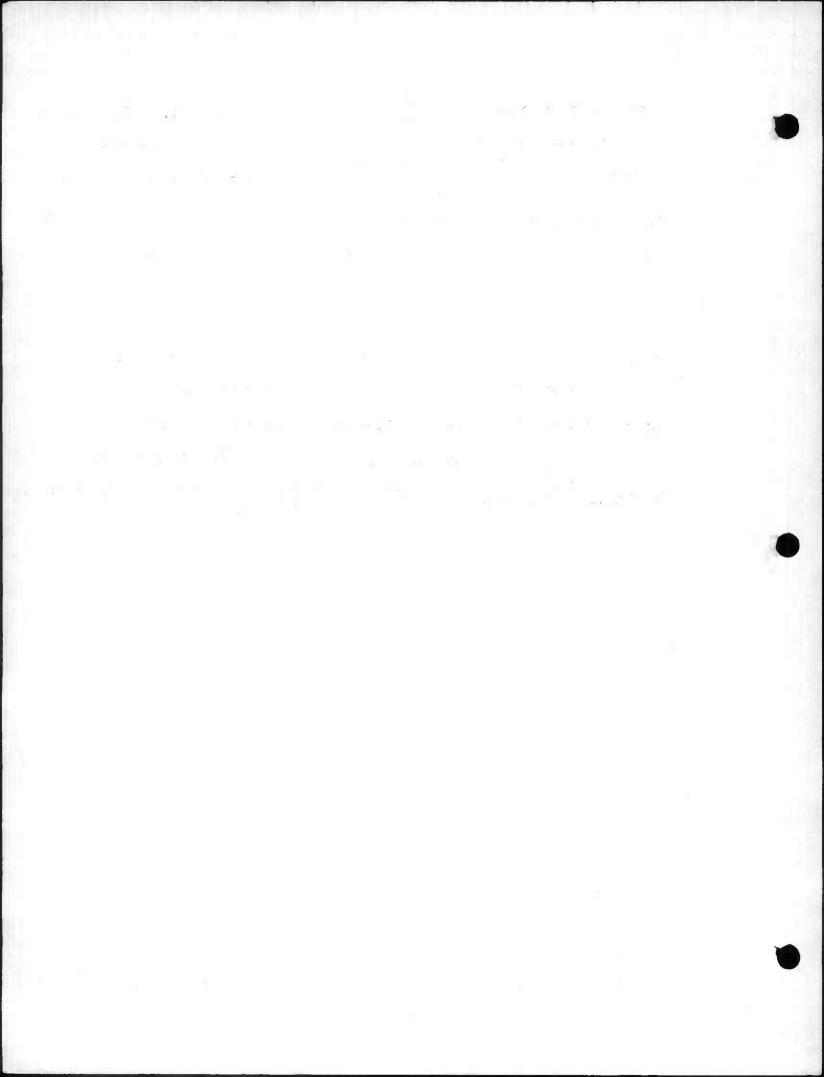
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	13.	30. Name and addre	ess of person	AK+	HAN!	72	220 /	ARI	< Ha	eg	HTS AVE	n Bi	440	M	021	208	
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Baltimore, Maryland 21215-0020

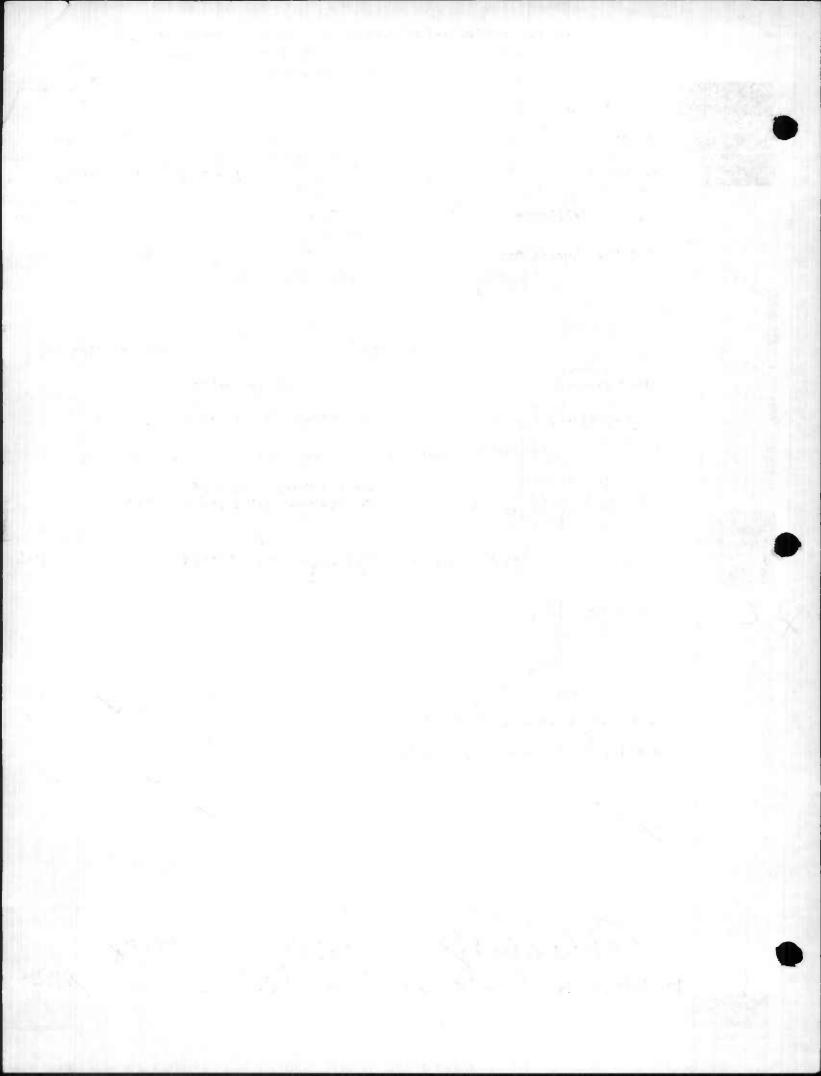
Division of Vital Records, P.O. Box 68760,



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	Medic xamin	_	4e. Facility Neme (If not institution		iber)		4	4b. City, Town, o	Location of Deet		of Death			
			1709 Glen Cur				Milled	Esse			Baltimore			
	neral ector		5. Social Security Number 407-32-8244 Usuel Residence of Decedent	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs.	1 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min	. (Month, D	rth ay, Year) 12,1927		9. Birthplace (State or Foreign Country) Kentucky		
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June imother KINUM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Bout under 1 Year If Under 24 Hrs. Sinau 5. Social Sacurity Number 6. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. X M 2 F Yrs. Director 215-02-6270 Jan.14,1967 Maryland Usual Residence of Decedant with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Directo Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 3817 Ridgewood Ave 21215 Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerlo Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: p 3 Widowed 4 Divorced Black Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Forklift Operator Warehouse 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Herbert Kinyon Carrie Bethea 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne H.Kinyon- Wife 3817 Ridgewood Ave Balto.Md.21215 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemetery6-4-98 Balto.Md. 22. Name and Address of Facility Caple Funeral Service 5502 Winner Ave.Baltimore, Md. 21215 Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, or heart to make this only one cause on each line. Approximate tritervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Due to (or as a obesequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or injury that initieled events rasulting in death) Lest Due to (or as a consequence of): 68760 Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown B Msuli þ 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of causa of daath? 1 PYes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ⊟Inpatient 2 ER/Outpatient 3 DOA ä 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: or Attending 1 Matural 5 Panding 1 Yas 2 No investigation 2 Accident Director 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 6 Could not be detarmined 3 Sulcide 28e. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 4 Homicide ŧ Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 8 To the P within 2 To the P 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licansa number

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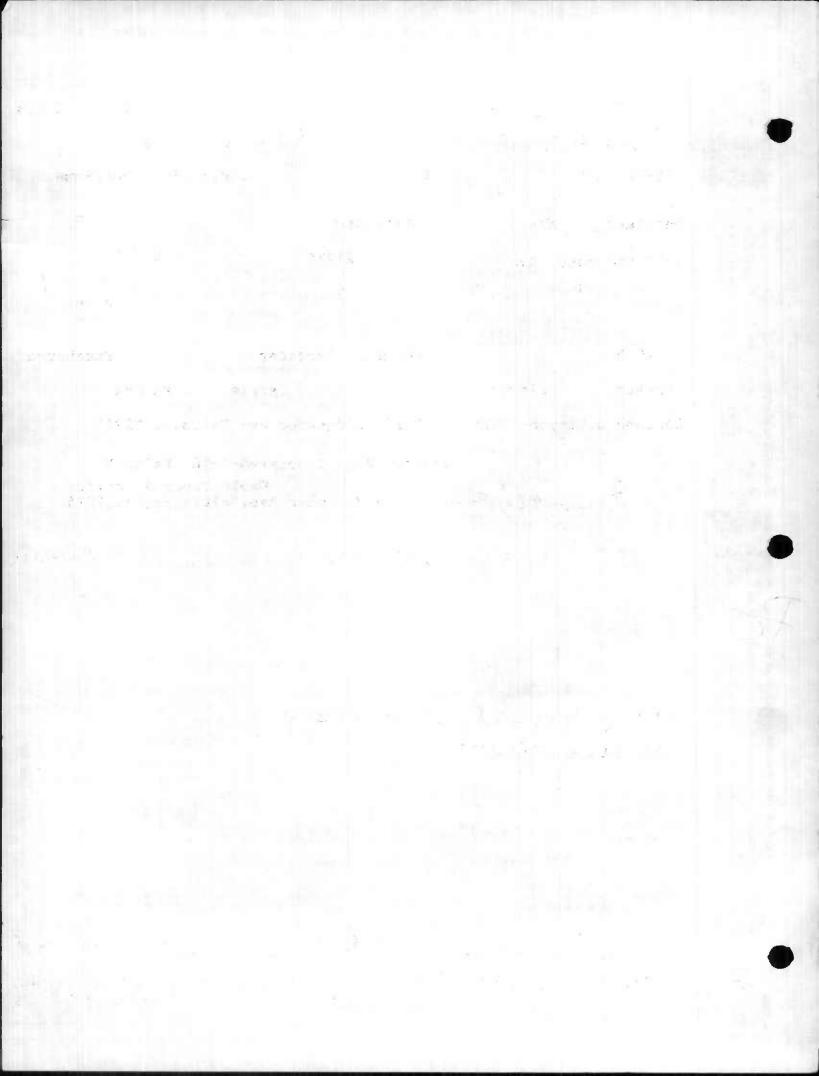
State Registrar 31. Dete filed (Month, Day, Year)

JUN 05 1998 32. Registrates Signature Andrews

ess of person who complated causa of death (Itam 23a) (Type, Print)

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Baltimore, MD 21215



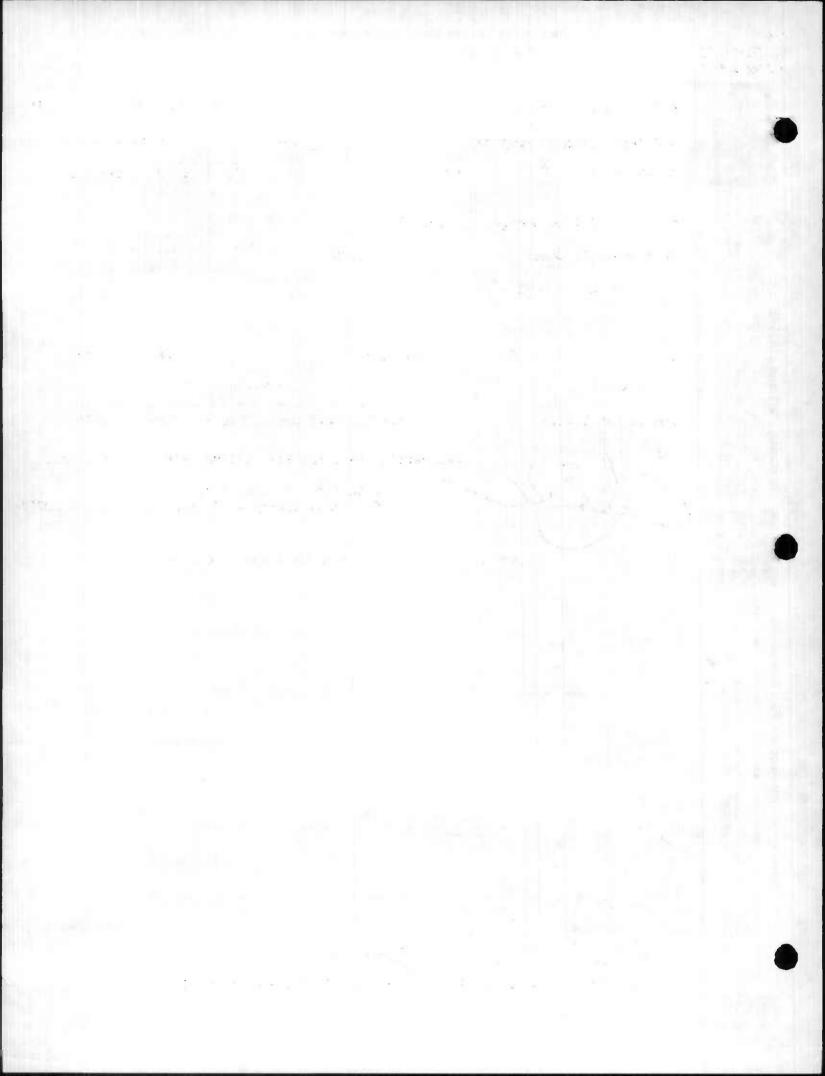
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State of Maryland / Department of Health and Mental Hygiene 98 17423

EN KOHEL			Certific	ate of	Death		Reg. No.		, , , ,					
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* /Medical					Ab Ciby Town or		2. Dete of Deeth JUNE 1, 1998 3. Tima of Death JUNE 1, 1998 2117 PM							
Examiner	4e Facility Neme (If not institution, g				4b. City, Town, or	Location of Dea								
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Funeral Director	387-52-4561	Sex 7. Age (In yrs. 1	Yrs. Mont			. (Month, D	ey, Year)							
Director	Usuel Residence of Decedent	1,7				riay 1	7,1747	WISC	Olistii					
ms 23a or 28a-f show crimat be notified at neral Director	10a. State 10b. County	10c. C	ity, Town or Location					10	Od. Inside City Limits					
be notified at	MD Prince George Laurel													
items 23s or 28s-fall first must be notified Funeral Director	10e. Street end Number	e dedige		Zip Code			10g. Citizen of	Whet Coun	try?					
23a or	7612 Woodruff C	ourt		20707			IISA							
items 22	11, Meritel Status	12 Was Decedent Ever in U				Specify Yes or N		2117 December 2117 December 2 December 2 December 3 December 4 Dec						
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) H	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:	1 □ Ye	s 2X No	Specify:		Specif	hite						
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termin T	19e. Informent's Neme/Reletionship	(Type, Print)	19b. Mailing Add	ress (Stree	et end Number or A	ural Route Numi	ber, City or Town	, State, Zip	Code)					
r trac	Pamela Kohel/Wi	fe	7612 W	oodru	ff Court	, Laurel	l, Maryl	, Maryland 20707						
othe	20e. Method of Disposition	20b.	complete a complete a cotto contrata					n - City or Town, State						
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any injury or other traumatic event, the Mannes. To Be Compl	21. Signature of Paneral Service Lio		dowridge Memorial Prk. 6/5/98 Elkridg 22. Name end Address of Fecility						aryrana					
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-	7601 Sandy Spring Road, Laurel, Ma 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, and the control of the ceuse on each line.													
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the funeral cation:	27. Manner of Deeth 1 Neturel 5 □ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju		28d. Describe	28d. Describe how injury occurred							
the f	2 Accident Investigati		М	10	Yes 2 No									
4	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injury - At I building, etc. (Speci		ctory, office		28f. Location City or To	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)							
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cai 🖈	29a. Certifier 1 Cartifying F	Phyelcian: To the best of my known or the basis of exemin	owledge, deeth occur	red et the t	ime, date and plec	e, and due to the	ceuse(a) end m	enner as st	ated.					
De De	one)	end manner steted.	ettori androi investiga	cion, in my	opinion, deeth occ	ones at the time	, date end piece	, and dde io	uio codse(s)					
completely filled in by Medical Certiff	29b. Signeture end title of certifier	1		29c. Licen	ise number		29d. Date sign	ed (Month, I	Dey, Year)					
X	Atanha	A 1/1 m	SEIMA	OCM	Œ		JUNE 2	1998						
F	30. Neme and eddress of person wh	o completed ceuse of death (Ite	m 23a) (Type, Print)				30111 41	2000	THE PARTY					
	Stephen Radentz			Balti	more, Ma	ryland :	21201							
State	31. Date filed (Month, Dey, Year)	32 Registrar's Sign	eture			1								
legistrar	JUN 0 5 199	18 Julia Sau	idson-Pandel	2										
Day 6005	UNIT U U	0												

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 7:15 P.M. Mary Elizabeth Kahl 1998 June 01 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health of Forest Hill Forest Hill Harford 5. Social Sacurity Number If Undar 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Days 1 M 20 F 75 217-12-7846 Yrs. Maryland Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Perry Hall 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Perry Hall Road 21128 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Giva Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Navar Married 2 Married 1 Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilaga (1-4or 5+) 12th grade Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Dennis Elsie Orems 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Wanda Bertorelli (daughter) 800 Seneca Park Rd., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, cramatory or other placa) 20c. Location - City or Town, Stala 1 Buriai 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. 6/5/98 Baltimore, Maryland 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or haar failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consaquence of): Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consequance of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Ohknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of daath? performed? 1 Yes 2 No

Physician /Medical **Examiner**

The law requires that the death certificate be executed

of Vital Records, P.O.

Division

Physician

/Medical

Examiner

Funeral

Director

25a-f show ns 23a or 25a-f show must be notified at

Director

Completed by Funeral

event, the Medical Examiner 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or itse

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Hygiene.

permit. Pages 1 and 2 at Department of Health arv Important: If Nem 27 is r any Injury or other traus

Maryland 21215-0020

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Completed by Physician/Medical Examiner

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ai Director: After th funeral

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or Attending Physician:

To the Hospital within 24 hours To the Funeral L

25. Was case referred to medical examiner? 1 Yas 2 27. Manner of Death

29a. Certifier

(Check only

1 Natural
2 Accident 3 Sulcida 4 T Homicide

5 Pending Invastigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3D DOA 28a. Date of injury (Month, Day Year)

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

1 ☐ Yas 2 ☐ No

Other: 4 Jursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Daath (Check only ona)

28f. Location (Street and Numbar or Rural Route Number, City or Town, Stata)

Cartifying Physician: To the best of my knowledge, death occurred at tha time, date and piace, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basts of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and due to the cause(s) er: On the basis of exa 29b. Signature nd titla of certifiar

29d. Data signed (Month, Day, Year)

complated cause of daath (Itam 23a) (Type, Print) 30. Nama and addrass of parson who ANNA れく (LIC (01

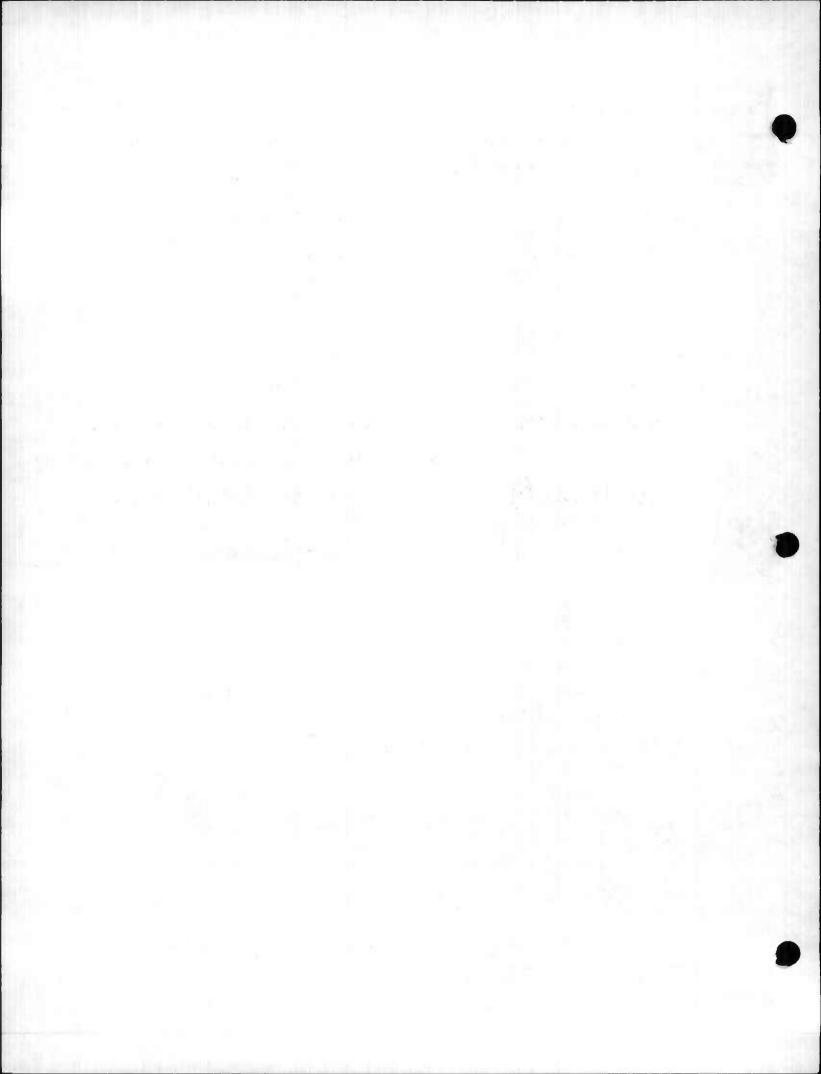
31. Date filed (Month, Day, Year)

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32. Registrar's Signatura

Fulla Navidon Randale

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month 20 50 JUNE 1998 RENE 4a Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death 3ALT imore tospita If Under 24 Hrs. If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 M 20 F 212-32-9767 Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No 10e. Streel and Number 10g. Citizen of What Country? SA Raca - Amarican Indian, Black, White, alc. Was Decedani of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedant Evar in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Yaar or Datas: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) DT 17. Fether's Name (First, Middle, Last) ames 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2/229 19a. Informant's Name/Relationship (Type, Pnnt) 20b. Place of Disposition (Name of 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice-Licensee GIIMOR 1402/217 23a, Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart feilura. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) RESPIRATURY FAILURE days Due to (or es a consequence of) YEUrs Heart Frilare CUNGESTIVE Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): CARdio MYO MA 1hy HYPERTROPHIC YEARS Due to (or as a consequence of): HYPERTENSION Years 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to complation of causa of death? 24a. Wes an autopsy 1 ☐ Yes 2 No 1 Yes 20 No 26. Plece of Death (Check only one)

Physician /Medical Examiner

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Physician

/Medical

Examiner

Funeral

Director

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Director

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Physician/Medical Examiner

Completed by

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Certification:

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Records, P.O. Box 68760 Division of Vital or Attending Physicien: death. Director: /

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Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Wes case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 29a, Certifier 1x Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the ceuse(s)

29b. Signature and title of certifier SAMIR KHEIRL

29c. License number P11073 29d. Dale signed (Month, Day, Year) Tune 13, 1948

Bultimure

Mb 21229

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

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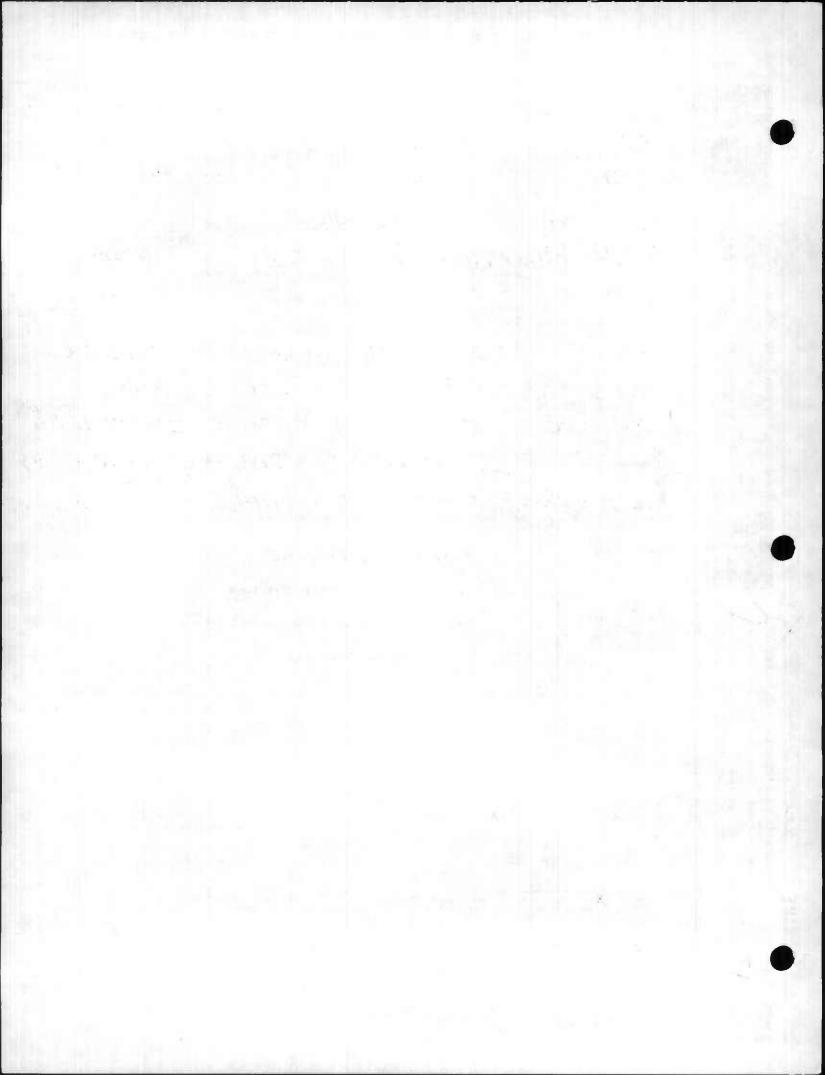
- ST AGNES HOSPIEAL - 900 Caton AVE. SAMIR KHEIRL

Registrar

31. Date filed (Month, Day, Year)

JUN 0 5 1998

32. Registrer's Signature Alia Savidson Randall



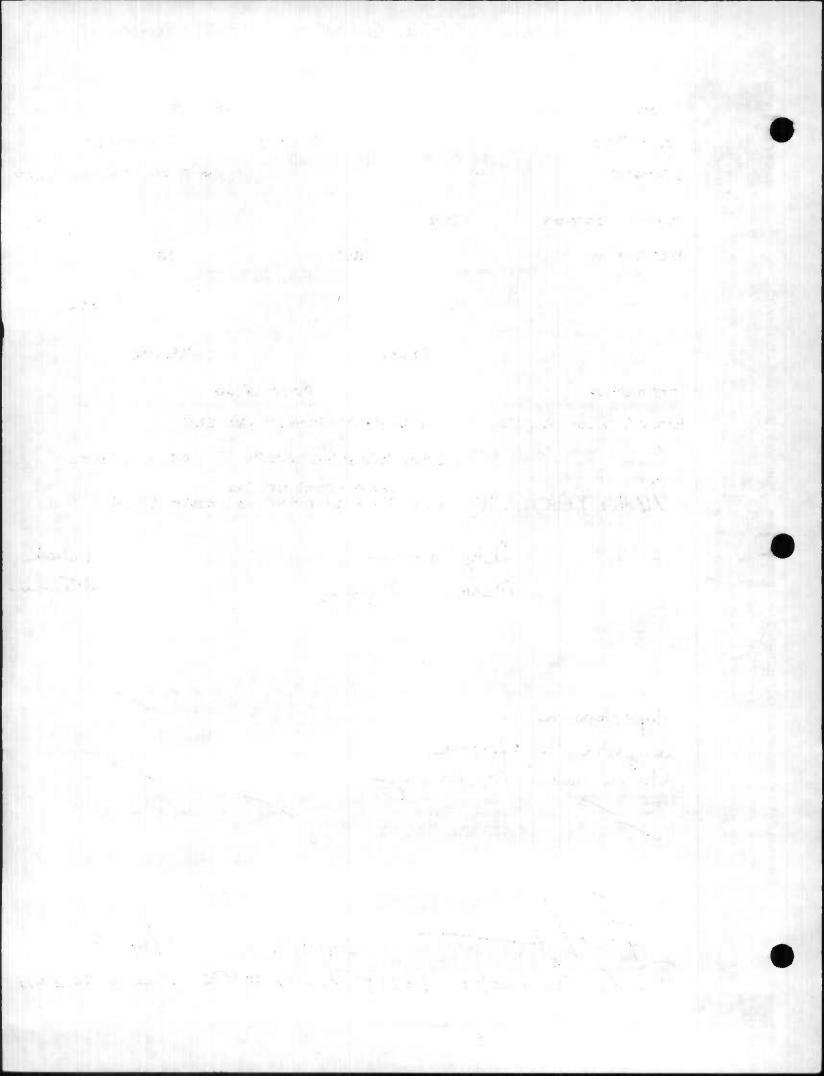
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month **Physician** F. June 3, 1998 Vincent LaPiana 9:05 a.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore City Hamilton Manor Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min 1□M 2□F Yrs. 90 Director 212-28-2152 October 8, 1907 Milwaukee, Wisconsin Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Ashton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 17801 Pond Road 20861 USA Funeral 72 hours after death 12. Was Decedent Ever in U,S.
Armed Forces?
1 12 Yes 2 □ No
If Yes, Give
Year or Dates: WW Ⅱ Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "sey injury or other traumatic event, fin Men. Elementery/Secondary (0-12) College (1-4or 5+) Colonel U.S. Army 12 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Francis LaPiana Olivia LaPiana 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Francis G. LaPiana, M.D. (Son) 17801 Pond Road Ashton, Maryland 20861 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State June 16, 1998 Arlington National Cem. Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility eny in Lassahn Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 7401 Belair Road Baltimore, Maryland 21236-4625 Approximete Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in deeth) Jeek Examiner Que to (or as a consequence of) Physician/Medical Examine Alzheimer's Disease Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) thet initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box The law requires that the death 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? Chronic renal certificate 1 ☐ Yes 2 J.M 1 Tyes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) P 1 Yes 2 Info 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 1 (Matural 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 5 Pending investigation 1 Yes 2 No death i Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide aftar 24 hours 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and menner as stated. 29a. Certifie edicai On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29c. License number 2 no completed cause of death (Item 23a) (Type, Print) # 470 Lotherille MO 21093 10 uwaer au

State Registrar 31. Date filed (Month, Dey, Year,

JUN Q 5 1998

32. Registrar's Signature

Julia Davidson Gandall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 10e,19b per F.H.G-760 6/5/98 reb 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** MARSHALL LILLIAN AIM 4c. County of Death /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Ne Balt If Under 24 Hrs. 8 tue Wood 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthdey) 6. Sex **Funeral** 220-18-8736 1 □ M 2 🕱 F Months Days Hours Director Vlana Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? /16181 di 000 Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marltel Stetus 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1□ Yes 2No Completed by Specify: Arican American 3 Widowed 4 □ Divorcad 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Cashier Ketai ompanies 0 permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is merked oths any injury or other traumetic event. 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Be 2 lonta ome lheresa 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, 1618/ 11/ (Brother) 19e. Informant's Name/Reletionship (Type, Mr.Herber to, 1 20b. Plece of Disposition (Neme of cemetery, cremetory or other p Wood Id al 20a. Method of Disposition 20c. Location -1 X Burial 2 ☐ Cremation 4 Donation 5 □ Other (Specify) 22. Name end Address of Facility Joseph L. Ru 21. Signal ge of Funeral Service Licansee Joseph L. Russ Funer 2222 W. North Ave. B List only one ceuse on each line. 21216 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel GASTRO-INTESTIMAL Bleeking disease or condition resulting in death) Examiner Examiner ANEMIA -Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that i P.O. Box 68760, ARTERED ScleenTie HEART WISCASE Physician/Medical thet initiated events resulting In death) Lest Due to (or as e consequence of): The law requires that the death certification Hemo THERA Part II. Other algniflcent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ģ 90 Completed 24b. Were eutopsy findings available prior to completion of cause of death? pege 2 should 24e. Wes en eutopsy performed? this certificate 1 Yes 2 INO 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ No 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred : After t 5 Pending Investigation death. 1 Yes 2 No To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fi 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and pleca, end due to the ceuse(s) and menner es stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(a) and manner stated. 29a. Certifier Medicai (Check only onel 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

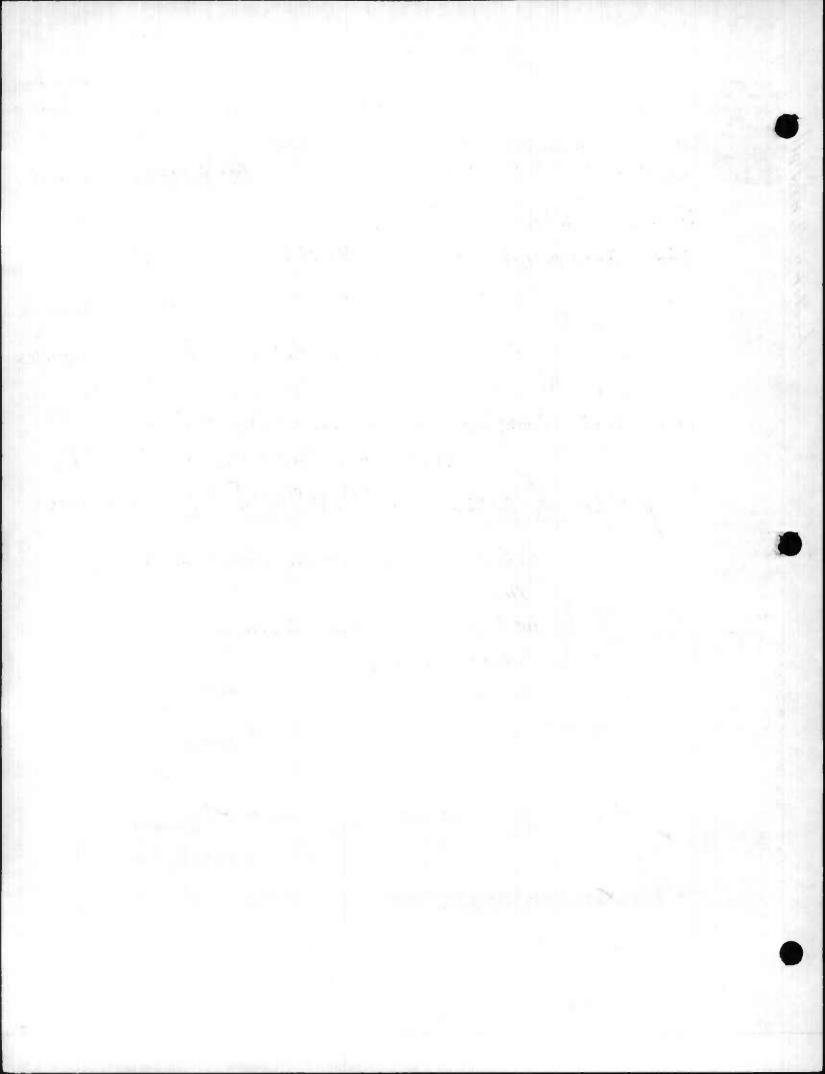
State Registrar deduny

31. Dete filed

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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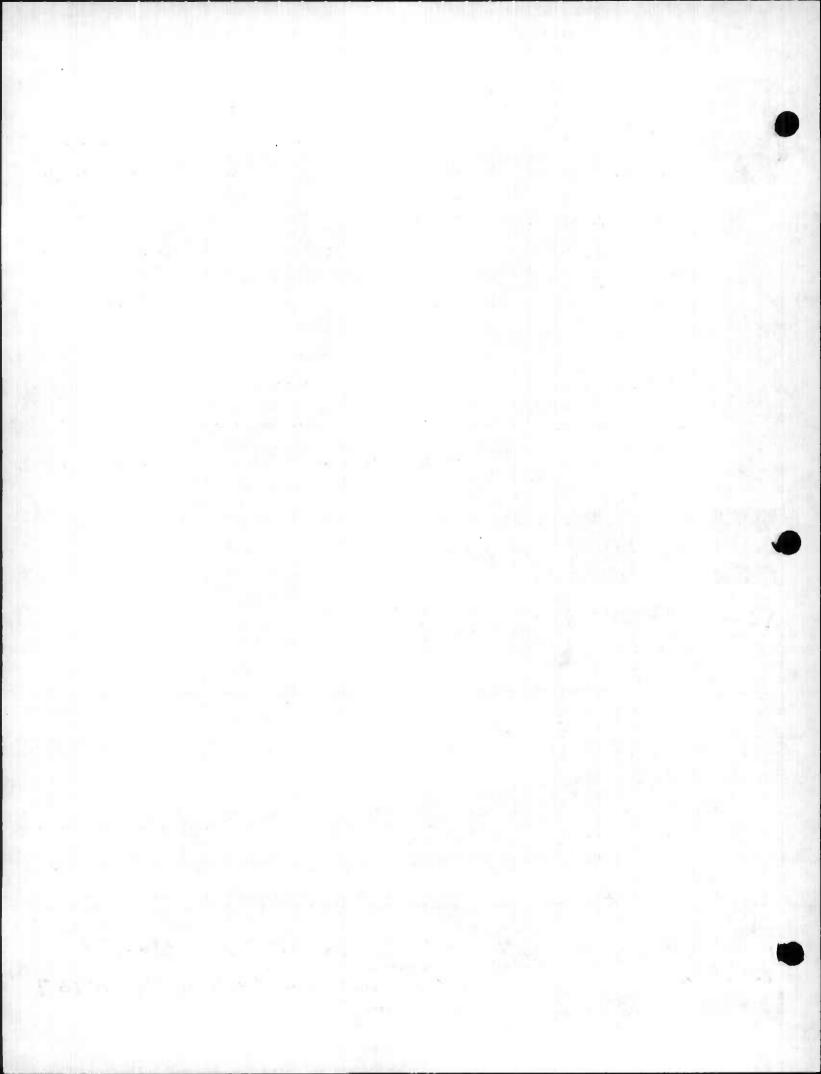


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 29 1998 Harold E. 5:00 A.M. May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5601 Haddon Drive Prince George's Lanham 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Dave 1∏M 2□ F Hours 174 20 7311 69 Director July 15 1928 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-1 show 10d. inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Moorcal Examiner must be notified at ¥2 Yes 2 □ No Directo Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5601 Haddon Drive 20706 United States Funeral 12. Was Decedant Evar in U.S. Armed Forces? XDE Yes 2 □ No If Yas, Giva Yaar or Datas: Korea 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 14. Raca - American Indian. Biack, White, etc. 1 ☐ Navar Married XX Married Maryland 21215-0020 1 ☐ Yes ZXNo Specify: Specify: White þ 3 Widowed 4 Divorcad Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Sacondary (0-12) College (1-4or 5+) I.B.M. Engineer 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Z. Mann Marguerite Brown 2 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Haddon Drive Lanham Maryland 20706 Charlotte F. Mann Wife Baltimore, 20b. Place of Disposition (Name of camefary, crematory or other place) June 1, 1998 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial Z⊠Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) The Huntt Crematory Waldorf Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. vans Mes 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Desth **Physician** /Medical Immediata Cause (Final diseasa or condition resulting in death) · ARTEMOSCIEROTIC HEDRT DISEase **Examiner** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediata ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical or Attending Physician: The law requires that the death certificate to Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Winknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performad? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese rafarred to medical examinar? Be 28. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA efter death. Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Piace of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a, Certifian Medical (Check only one) 29b. Signatura and title of certifian 29d. Data signed (Month, Day, Year) 521171572 (can br 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) Roger B. Ingham 6510 Kenilworth Ave Riverdale Md 31. Date filed (Mon 32. Registrar's Signature State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year GEORGE McCULLOCH June 1998 0850 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth North Arundel Hospital Glen Burnie ANNE ARUNDEL 5 Social Sacurity Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 07/17/1932 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign Country) 11XM 2□ F Days Hours 65 018-24-3293 Yrs MA Usuei Residence of Decadant 10h County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 □ No SARASOTA SARASOTA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1674 UNIVERSITY PARKWAY #265 34243 U.S.A. 12. Wes Decedent Evar In U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 XNever Married 2 Merried 1 XYes 2 No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) TRUCK DRIVER CEMENT INDUSTRY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) GILBERT E. McCULLOCH EVELYN LINDALL 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARION DUFFTY/SISTER 11 BELOIT STREET, DEDHAM, MA 02026 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, Stata MASSACHUSSETTS NATIONAL CEMETERY 1 XBurial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 6/5/98 BOURNE, MA 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 deurs 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Reh Onsat and Deeth Immediate Cause (Final AIDS diseese or condition resulting in deeth) Few Years Due to (or es e consequence of): Due to (or es e consequence of) Dua to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medicai Examiner

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7 is marked other than "natural", or hems 23s or 28a-f show traumatic event, the Medical Examiner must be notified all

permit. Peges 1 and 2 should be filed within 72 hours efter to Depertment of Health and Mental Hygiene. Important: If Itam 27 is merked other than "natural", or Health Inlury or other traumatic event, the Medical Experimenty Inlury or other traumatic event, the Medical Experiments of Inlury or other traumatic event, the Medical Experiments.

Saltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

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Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events rasulting in death) Lest Physician/Medical phys the 98

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I.

25. Wes case referred to medical 1 XYes 2 No

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dev Year) 28b, Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Dascribe how Injury occurred

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27. Manner of Deeth 5 Pending 1 CiNetural investigation 2 Accident 6 Could not be determined 3 Suicide

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, ferm, straat, factory, offica building, etc. (Specify)

28f. Location (Straet end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 - Homicide

1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signature and titla of cartifian

31. Dete filed (Month, Day, Year)

Deputy

29c. Licansa numbar

29d. Date signed (Month, Day, Year)

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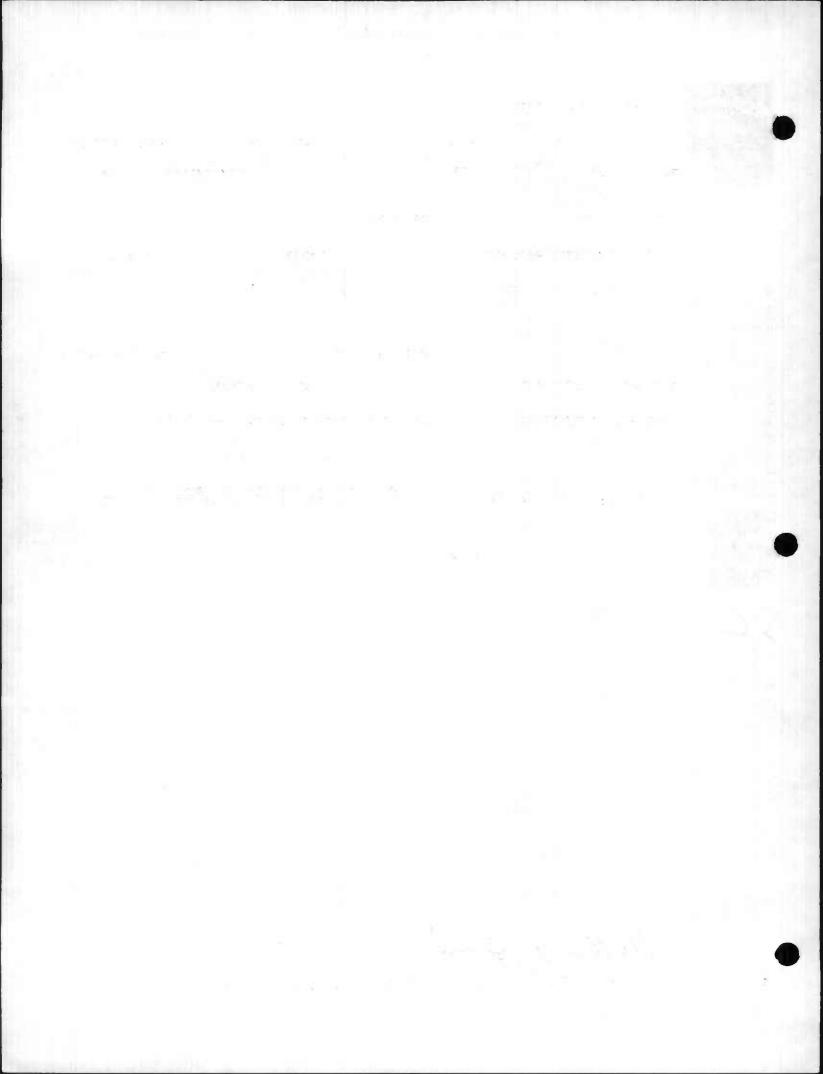
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6-1-98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

William P. Jones, M.D. 695 America Court

State Registrar 32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** AGNES MADER MAY 8.20 MM 30 - 1998 /Medical 4e. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** SHADY GROVE NURSING CENTER ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Min. A PK 119. Day, Year 149. 14 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplece (Stata or Foreign 1 M 200 F 472 09 8604 84 Yrs. MINNESOTA Director Usuel Residence of Decedent MONT GOMERY City, Town or Location GAITHERSBURG The 23e or 28e-f show 10d. inside City Limits MD. Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9505 PECAN GROVE TERRACE 20882 UNITED STATES Herns 2 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, The Medical Examiner Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours efter nent of Health end Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 Never Merved 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: WHITE 1 ☐ Yes 2 No Specif þ 3 ☐ Widowed 4 ☑ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usuei Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) BOOK BINDER PUBLISHING COMPANY traumetic event, 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be ALGOTT JOHNSON (UNKNOWN) 19a. Informant's Neme/Relationship (Type, Pr JEROME J. MADER/ SON 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 9505 PECAN GROVE TERRACE, GAITHERSBURG, MD. 20882 other 20b. Piece of Disposition (Nama of camatary, cramatory or other place) METROPOLITAN CREMATORY 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or 5/31/98 ALEXANDRIA, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23e. Pert1. Ehter the disease or compilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediete Ceuse (Final disease or condition resulting in deeth) **Examiner** Examiner Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of) Physician/Medical Due to (or es a consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ Completed 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 2 No 1 Yes 2 No Be 25. Was cese referrad to medical 28. Piace of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical-Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Maturel 1 Yes 2 No

If or Attending Physician: The law requires thet the death certificate be executed after death.

Director: After this certificate has been signed by the ettending physician and din by the tunerel director, page 2 should be detached for use as the humaning and the times as the humaning that the second to the second terms as the humaning that the second terms are the humaning terms. Division of Vital Records, P.O. Box 68760.

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Baltimore. Maryland

2 Accident 6 Could not be 3 ☐ Sulcide 4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner steted. (Check only 29b. Signeture end title of

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

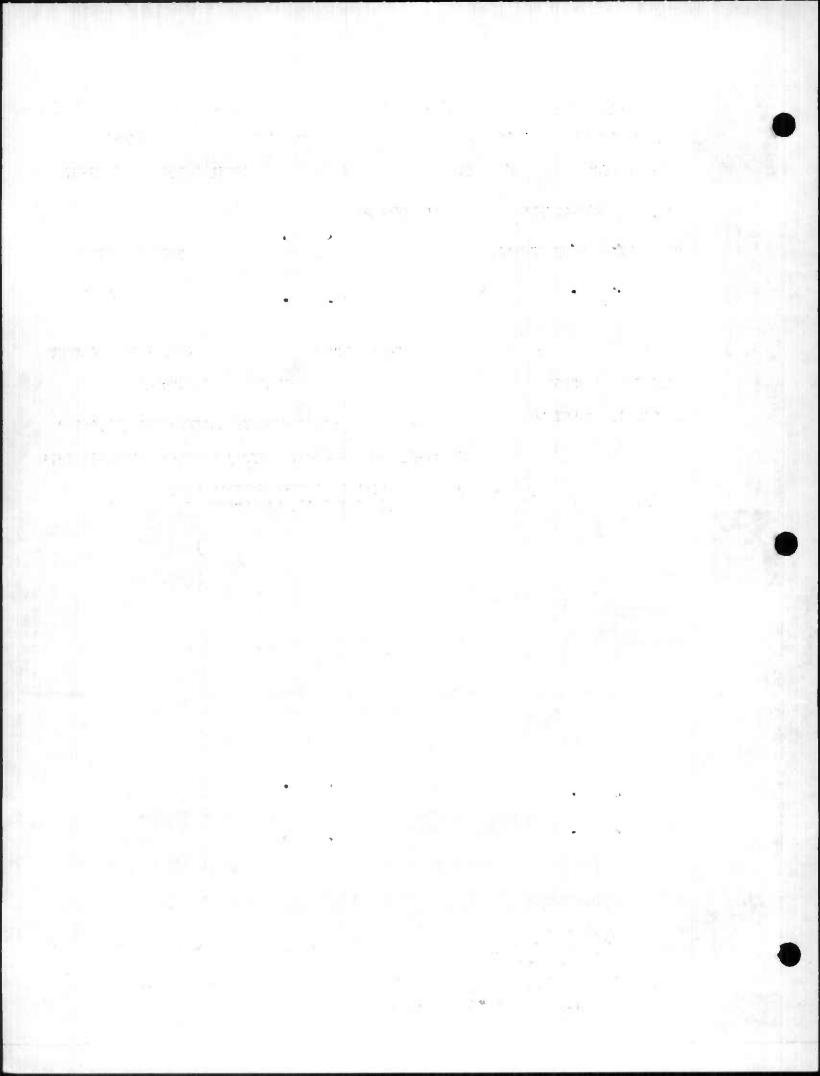
ed ceuse of death (item 23a) (Type, Print)

W. EDMONSTON DR, ROCKVILLE, MD.

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

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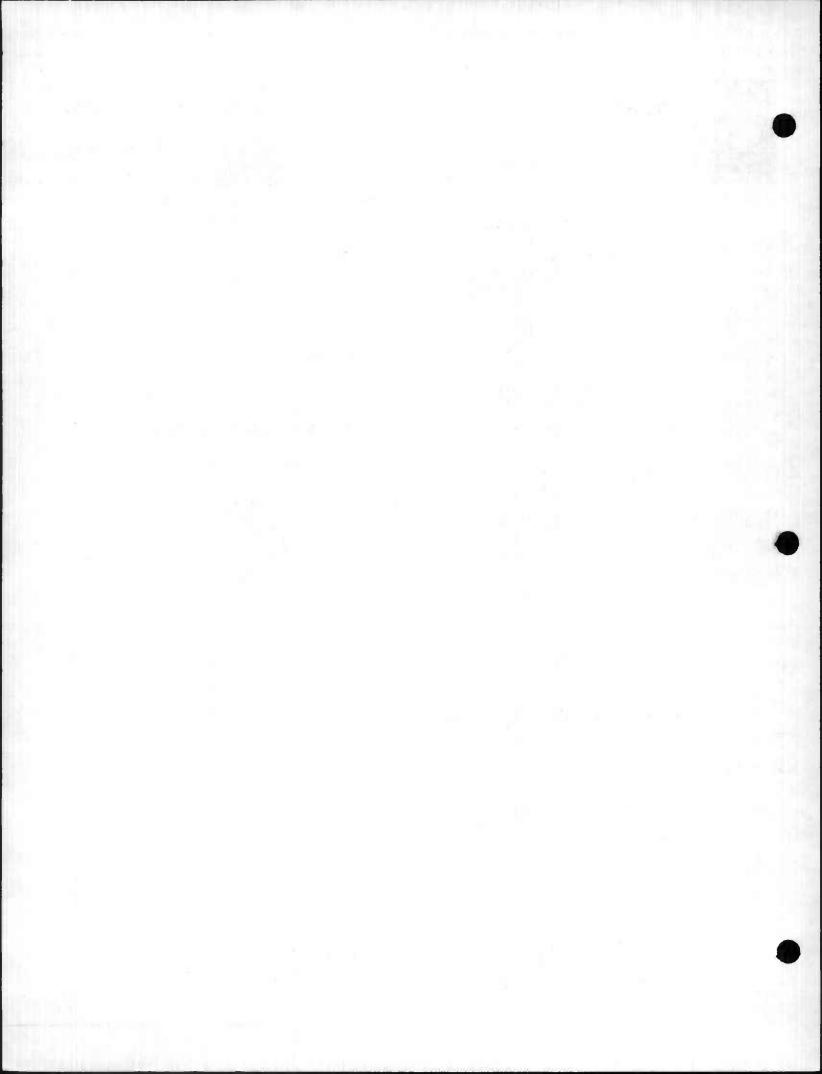
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Phys /Me	ician dicai	1. Decedent's Name (First, Middle, Last) Augusta Sample				Nowli	1			2. Date of D Month May	May 30 199		3. Time of Death 2:45 a.m.	
For death with the Meryland For 23a or 23a-7 show terming the profilmed at mer mer the profilmed at the pro	edicai niner eal	4a. Facility Name (# not ins BROADMEAD 5. Social Sacurity Number 216-46-3491 Usual Residence of Decede 10a. State 10b. C Maryland Bal 10e. Street and Number	RETIR 6.5 out tounty Road	Pe street end num EMENT Conserved to the conserved to the country 12. Was Dece	OMMUNT 7. Age (In yrs. 94 10c. Ci	MMINITY Age (In yrs. lest birthday) 94 Yrs. If Under 1 Year If Under 24 Months Days Hours I 10c. City, Town or Location Cockeysville 10f. Zip Code 21030 Int Ever in U,S. Se? No 1 Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of life. Do NOT use retired) College Instructor			COCKEY If Under 24 F Hours N	or Location of Dec SV111e Trs. 8. Date of B in. Month, L Dec 1.	Baltimore Pay, Year) 10g. Citizen of What C		10d. Inside City Limits 1 □ Yes 2 ☑ No ntry? can Indian,	
d Z1Z15-00Z0 illed within 72 hours aft hygiene. ther than "natural", or nt, the Medical Exam	Completed by f	3 ₩ Widowed 4 □ Div	edent's Enighest gre	if Yes, Giv Year or Da ducation ade completed) College (1	e Transities:					16b. Kind of E	usiness/ir			
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Stood, Ale De executed American and American and American and Americansit Amer	n al	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to Immediate cause. Enter Undarfulate cause. Enter Undarfulate cause (Disease or Injury thet initieted events resulting in death) Last			Due to (c	th. Do not ent	er the mode quence of):	1-Wi ork R of dying,	edefel oad I such as card	Id Home Baltimore Blac or raspiratory	Maryl	and 2	Approximata Interval Between Onsat and Daath	
at the deeth dby the etter deteched for u	Completed by Physician/Me	Part II. Other significant co	^	dontributing to de	DISCASE							3 ☐ Pro	bute to the cause of death? Probably 4@Unknow 4b. Were autopsy findings available prior to completion of cause of death?	
ng Physician: fler this certifica	Certification: To Be Cor	2 Accident in	edical ending vestigation ould not betermined	28a. Date o (Month	f Injury 7, Dey Year)	28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 1 Yes 2 No 28d. I					1 ☐ Yes 2 Ø No 1 ☐ Yes 2 Ø No heck only one) 5 ☐ Residanca 6 ☐ Other (Specify) Describe how injury occurred Location (Street end Number or Rural Route Number, City or Town, Stete)			
To the Hospital or Attandi within 24 hours efter death. To the Euneral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) 29b. Sign thin and title of 3 30. Name and address of pe	Privier	om pleted cause	er stated.	owledge, death occurred at the time, date and pleation and/or investigation, in my opinion, death occurred at the time, date and pleation and/or investigation, in my opinion, death occurred by the state of the time, date and pleating the time, date and dat			curred at the time	, date and place,	and due t	o tha cause(s)		
	State	31. Date filed (Month, Day,	(ear)	32 8	>GFGC		l:	500(LOP	K Ild	COCKO	Esul	SPF TO WAY	



WRC 980-2666-031 RAYMOND

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Items: 23 part.I.II.27 per MEO G-760 Certificate of Death Reg. No. NIZNIK 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death 11; Day 1998 ear **Physician** MAST 1:15 AM RAYMOND EMIL NIZNIK /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) Feb. 22,1944 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) California 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 54Yrs. 387-42-3834 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f ahow traumstic event, the Moxical Examiner must be notified at 1 ☐ Yes 2 No Director Va. Fairfax Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with U.S.A. 1819 Batten Hollow Rd. 22182 2 should be filed within 72 hours after death in and Mental Hygiene.
Is marked other than "natural", or items 23. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifte. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Director of Pensions Lockheed/Martin Corp. 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille Mrozek Emil Niznik 2 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: if item 27 le n any Injury or other traur Brooke S. Niznik (Wife) 1819 Batten Hollow Rd., Vienna, Va. 22182 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/14/98 Chantilly, Va. Cremation Center Signeture of Funeral Service Licenses 22. Name end Address of Fecility Murphy Falls Church F.H. Falls Church, Va. 22046 23a. Part1. Enter the disease, or censhock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting In death) /Medical ATHEROSCLEROTIC CARDIOVASCULAR DISEASE **Examiner** Due to (or as a consequence of): Examiner physician and s the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as e consequence of): Box 68760. Physician/Medicai certificate Due to (or as a consequenca of) 88 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the i signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medicel examiner?

↑♥ Yes 2 No Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending or Attending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medicai To the Hosp within 24 hou To the Fune completely fi (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

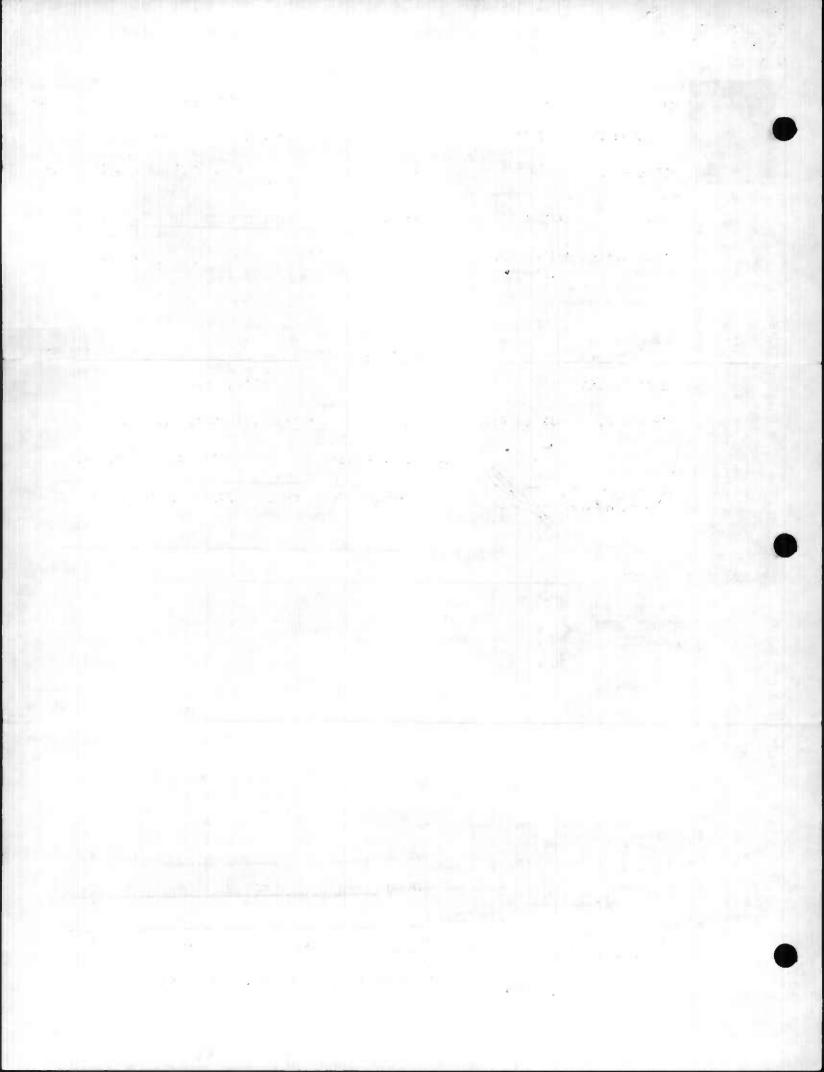
O.C.M.E.

12, 1998

State Registrar

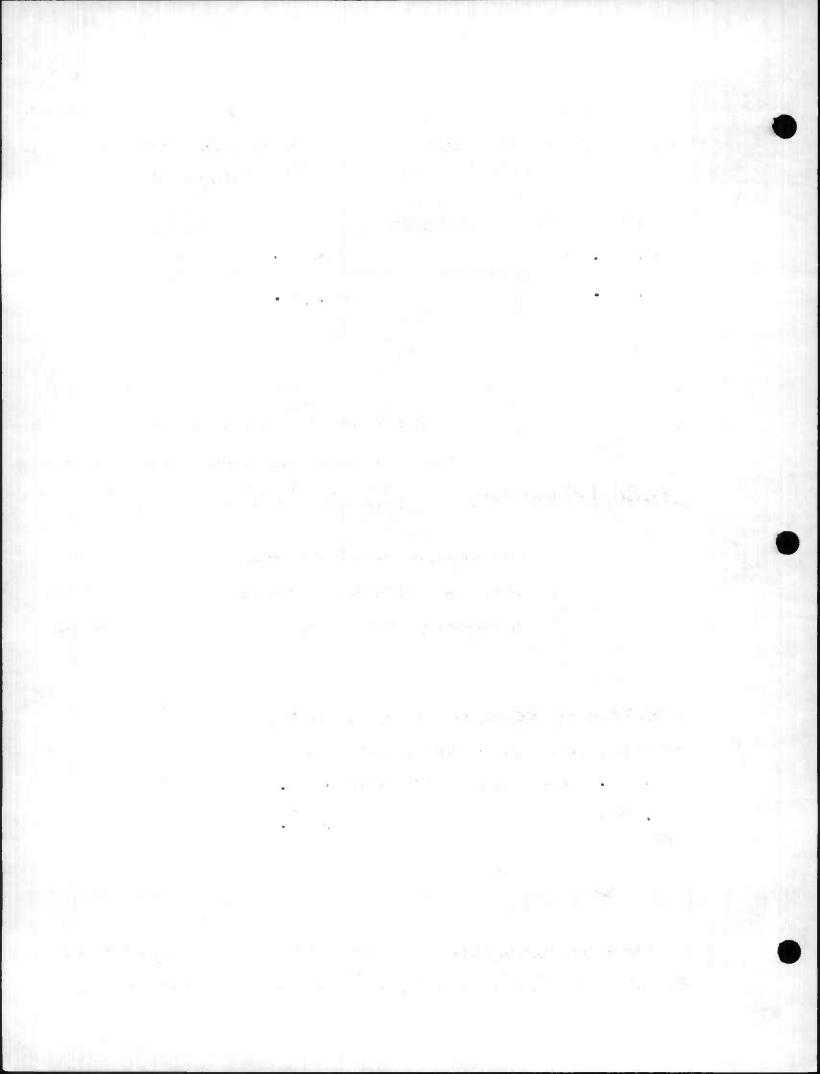
111 Penn Street, Baltimore, Maryland 21201 Radentz Strohen 33 Registres Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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,	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Olive Geraldin 4a. Facility Name (If not institution, give street)		lusbaum		4b. City, Town, or Lo	2. Date of Dea Month 05 ocation of Death	Day 28	Year 98 of Death	3. Time of Daath 9:39 a.m.			
	Funeral Director		Western Maryland Hosp 5. Social Security Number 6. Sex 220 28 7586 1□ M	oital Cente		If Under 1 Year Months Days	Hagersto If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day January 2	, Year)	ington 9. Birthol Count Mary	ace (State or Foreign try)			
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Maryland h and Mantai Hygiene. 7 is marked other than "natural", or items 23s or 28s-1 show treumstic event, he Medical Exemples must be notiled	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick		10c. City, Town or Location Middle town						0d. Inside City Limits			
	ath with th	rai Director	10e. Street and Number 8525 Rolivar Road			10f. Zip Code 217		10g. Citizen of What (
	al', or itame	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U med Forces? □ Yes 2 XNo Yes, Give ear or Dates:	If	Vas Decedent of H Yas, specify Cubi ☐ Yes 2∑ No	lispanic Origin? (Sp an, Mexicen, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, a w: Whit	etc.			
	within 72 ho ena. than *natur	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) 12	pleted) ollaga (1-4or 5+)	(Give I	O NOT use retired	during most of work	ing	16b. Kind of Business/Industry					
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Na	d 2 should it and Man	2	Clarence 19a. Informant's Name/Relationship (Type, P	Bothwell	10h Mailie	m Address (Ctreet	Goldie	Michaels al Routa Number, City or Town, State, Zip Code)						
	fend 2 s Haalth an em 27 Is r			ighter			Rd. Middl			769	Code)			
			20a. Method of Disposition 1	20b. F	Place of Dispos cemetery, crem	ition (Name of atory or other place	09)	Date	20c. Location -	City or To	wn, State			
Baltimore,	permit. Pagas Department of Important: If It any Injury or once.		21 Stopnature of Funerai Service Licensage 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac St. Hagerstown, Maryland 21740											
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each lina. Approximately a such as cardiac or respiratory arrest, interval B Onset an											
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Hecords,	@ _ W	Completed	REGURGITATION TRICUSPID REGURGITATION, performed?								allable prior to appletion of ceuse death?			
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OI <	physici this car	2	examiner? 1 Yes 22 No Hospit	1 □ Inpatient 2 □	ER/Outpatient		ar: 4 Nursing Ho	me 5 Resid		er (Specify)			
	i or Attending Physician: eftar death. Director: After this cartific d in by tha funeral director,	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could nice be 28	a. Date of Injury (Month, Day Year) e. Place of Injury - At he	28b. Tima of Injury oma, farm, stra		yat k? Yes 2 □ No	28d. Dascribe h	treat and Numb		l Routa Number,			
1	To the Hospital or within 24 hours effa To the Funeral Dire completely filled in I										ated.			
	Nithin 2	Medical		nd mannar stated.		29c. Licens			9d. Date signe					
	F 5 F 0		Mark Joines	m.M.D.		D 315	37		May :	28,/	998			
			30. Name and address otherson who completed MARK JAMESEN WE STAND TO STAND THE STAND TO STAND THE STAND TO STAND THE	ed ceuse of death (Itan	n 23a) (Type, F	Print) CEN	TER, HAGE	ERSTOW	N. MIN	2174	12			
ľ	Sta Registr	te ar	31. Data filed (Month, Day, Year) JUN 0 5 1998	32. Registrace Signa	ature Randa	202	7 11/1 0							



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Deeth 3. Time of Death Month **Physician** Izabeth Itmanns /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner HIMBRE KOSIOO If Under 24 Hrs. HOSOITAU Age (In yls. lest birthdey) If Under 1 Year Birthplace (State or Foreign Cauntry) 5. Sociel Security Number 6 Sex **Funeral** Deys Min 1 ☐ M 2 💢 F 66-579 Yrs **Director** Usuel Residence of Decedent 10a. State 10b. County City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2/2 100 AVE Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Maritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried Specity: White 1□ Yes 2 No Specify: by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YRS 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Tot 19b. Mailing Address (Street end Number or Rurgl Route Number, City or Town, Stete, Zip Code) 621 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete lune Important: If the any injury or o 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Vans 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one cause on each line. 21234 Approximete Intervel Between Onset and Deeth **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medicai **Examiner** Cardiovascular Disease Examine Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1□Yss 2NNo 3 Probably 4 Unknown 1 pertension þ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed Venostasis 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 N Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? 1 Netural 5 Pending 1 Tyes 2 □ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760 6 DB06 2 certificate director. 番 After Attending after 8 듬

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: if ifem 27 is marked other than "natural; or itema 23a or 23a-f ahow any injury or other traumatic event, the Mental Example Incomfact.

Baltimore, Maryland 21215-0020

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and menner as steted. Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner steted.

29b. Signature and title of

29c. License number

29d. Dete signed (Month, Dey, Year)

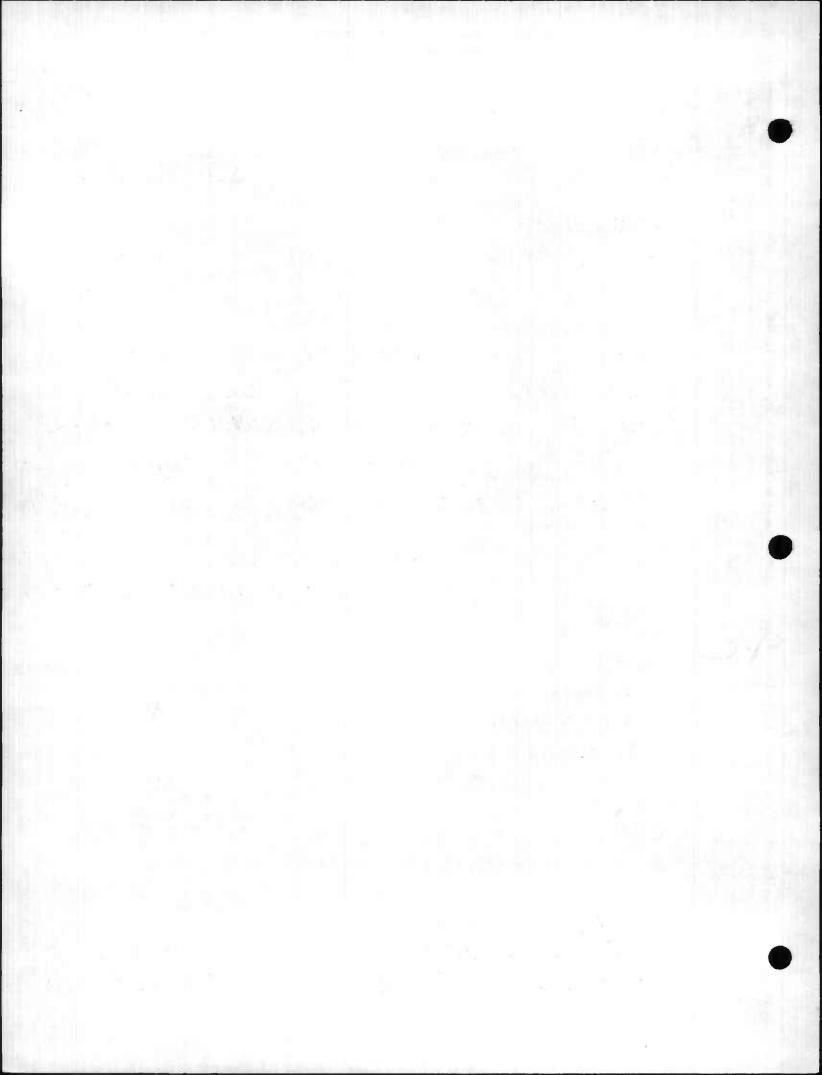
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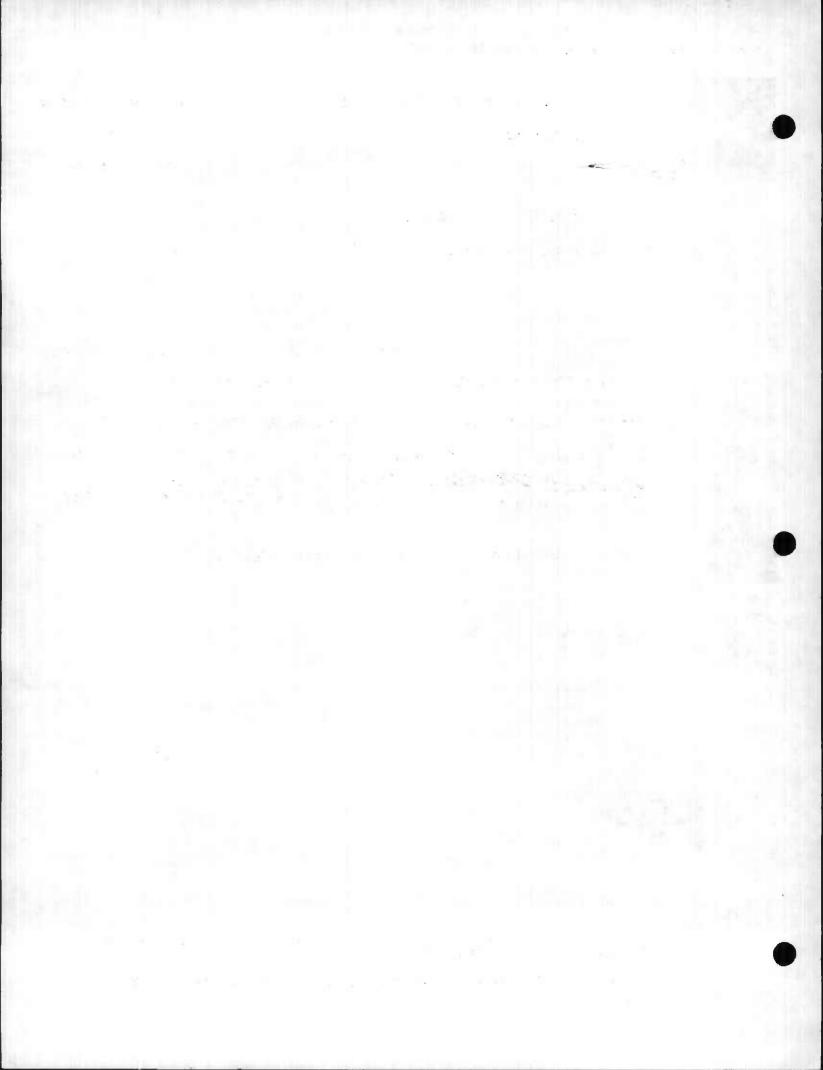
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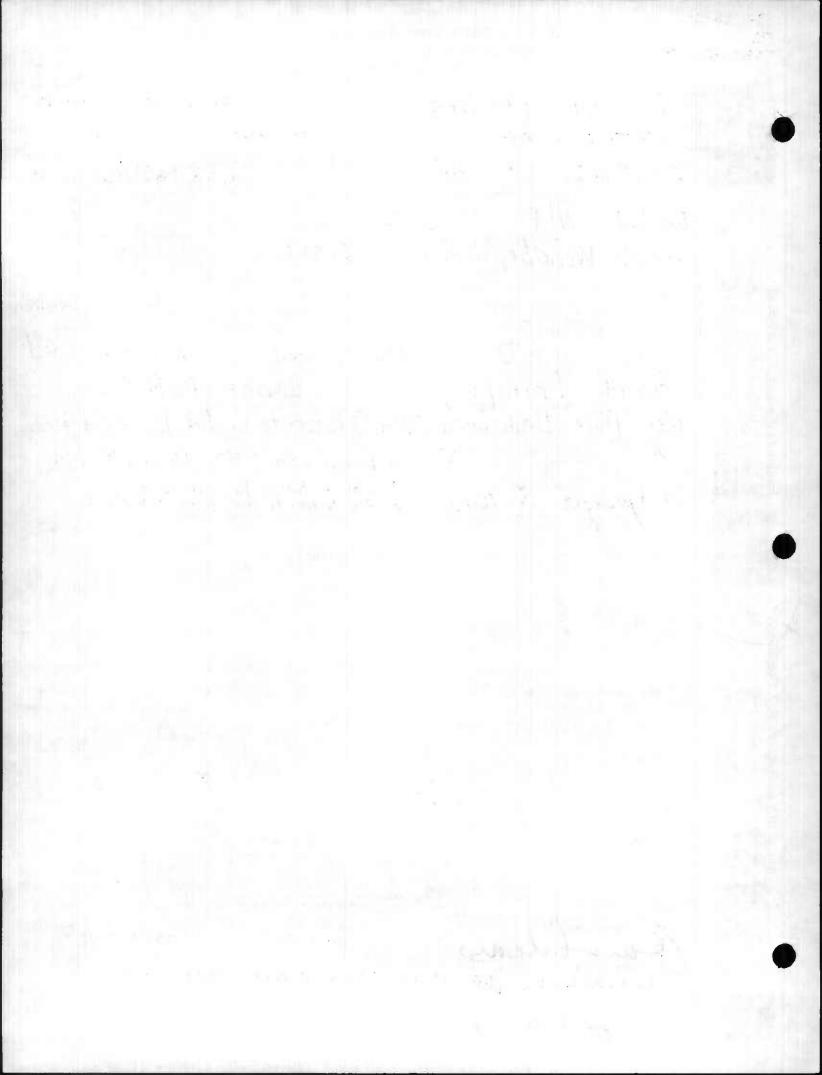
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uneral rector		5. Sociel Security Number 215 48 2017 218-78-6066 Usuel Residence of Decedent	6. Se	x 3M 2□ F		(In yrs. I	lest birthde Yrs.	y) If Und Months	er 1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Birt (Month, De) MAR 1,		_	olaca (State or	r Forei
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the or	2	10e. Street end Number 7550 Middlel	oure	Rd.	. Ap	t.	C		ip Code 2175	7			USA	0g. Citizen of Whet Country?		
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Important: I any Injury o once.		21. Signature of Funerel Serv	- 2	. / ~	N	1		22. Name Crem	atio	ss of Facility n Soc	iet	y of	Maryl	and,	Inc.	8
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		30. Name end eddress of pers	on who c	ompleted ce	use of de	eth (Item	23e) (Typ	e, Print)								
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director		5. Social Security Number 213 - 88 - 8620 1 Usual Residence of Decedent	ex 7. Age (In yrs 34	/ast birthday) If Uni Month	der 1 Year If Under 24 Hrs as Days Hours Min	Sept. 8	1963	Mary	State or Foreign		
	low in		10a. State 10b. County	10c. C	ity, Town or Location				10d. lr	nside City Limits		
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21215-0020	nours afte	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		2 No Specify:		Applicity	ican /	American		
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	0 5 5 0	To B	Kalph P	hillips		Dia	ne 1	10 Mi	llian			
ary	E E		19a. Informant's Nama/Relationship	Type. Prinu (Foster Mothe	19b. Mailing Addr	ass (Street and Number or R	ural Routa Number,	City or Town.	State, Zip Code	9)		
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ore	iges 1 an it of Heal if item 2 or other		20a. Mathod of Disposition 1 2 Burial 2 □ Cremation 3 □		Place of Disposition (f	Vame of pr other place)	///	20c. Location	City or Town, S	itate A A		
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Baltimore,	Department Important: any Injury once.		21. Signature of Funeral Service Licen	see PID	22. Name	end Address of Facility	Funeral	Home	,			
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400		Be C	25. Was case referred to medical			26. Placa of Da	ath (Check only on					
>		ToB	examiner? 1X Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	Other	Home 5 Reside		ner (Specify)			
			27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. injury at Work?	28d. Describe ho	w injury occur	rred			
Sio		ä	2 ☐ Accident Investigation	6/3/98	unknown M	1 ☐ Yes X 🖁 ☐ No	unknown					
	after dead Director: d in by the	Certification:	3 ☐ Suicide	28e. Place of Injury - At I building, etc. (Speci	tory, office	281. Location (St City or Town	reat and Numi	Woodbroo	ite Number,			
۵	ours at ours at meral Di			Home			В	altimore	, MD.			
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	To the Hos within 24 h To the Fun completely	Wex	29b. Agrature and title of certifier	and manner stated.		29c. License number	2	9d. Dete signe	ed (Month, Day,	Year)		
	F 3 F 6		N. G	leave		O.C.M.E			3, 1998			
			60 Nama and addrass of narrow who	completed cause of death (to	m 23a) (Type Print)							
			Ja CARON GOZ	completed causa of death (Ite	11 Penn St	reet, Baltimo	re, Maryl	and 21	201			
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer's Sign	aure Rand	.00						
	Dogista	0.	11111 46	On della .	MINDAMO - NOTO	And a						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Dev DORIS LOUISE SEIDENBERG PAZORNICK May 29, 1998 11:50 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Hebrew Home Of Greater Washington Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M ŽCKE 578-40-8929 Yrs. Director Nov. 7, 1926 Washington, DC Usuai Residenca of Decedent 10b. County District 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1718 Tamarack Street, N.W. 20012 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. l □ Yes 2 → No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No þ 3 Nidowed 4 Divorcad White Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 Years Coltege (1-4or 5+) Manager Real Estate 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Seidenberg Fannie Globus 2 19a. tnformant's Name/Retationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Item 27 is eny injury or other tracence. Raymond I. Pazornick, Son 1718 Tamarack Street, NW, Washington, DC 20012 ca of Disposition (Name of Date 20c. Location - City or Town, State 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Mikro Kodesh-Beth Israel 20c. Location - City or Town, State PD Buriel 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signeture of Funeral Service Licanses STEIN "HEBREW MEMORIAL FUNERAL HOME, INC. Tottlemyer 232 CARROLL STREET, NW, WASHINGTON, DC 20012 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each time. **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveltable prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? Be 26. Placa of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 10 28a. Date of tnjury (Month, Dey Year) 27. Menner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Coutd not be 3 ☐ Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760 The law requires that the death cert certificate has this After

must be notified at

traumatic event, the Medical Examiner 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or iter

at Hygiene.

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21215-0020

Maryland

Baltimore,

or Attending Physician: death. Director: 24 hours a Hospital

within 2

State Registrar

Medical

29a. Certifier (Check only

29c. License number D23958

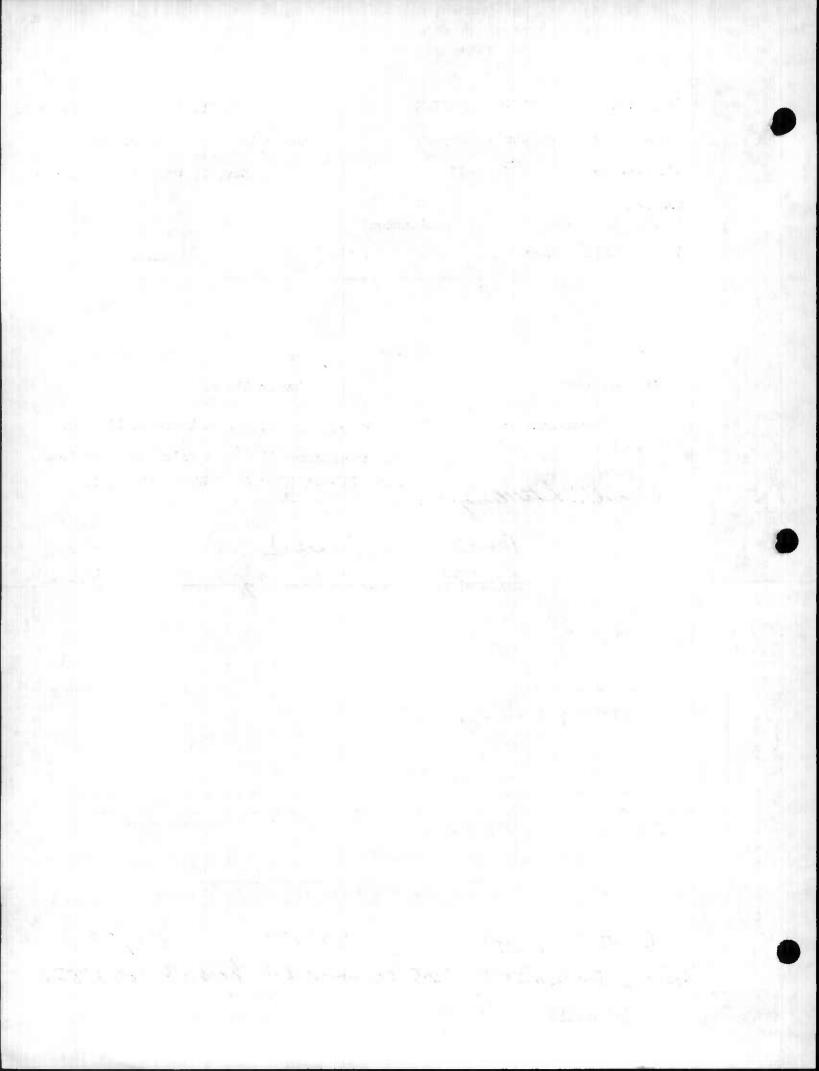
12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

30, Name and address of person who completed cause of death (ttem 23a) (Type, Print)
Bus T Feldman MD, 6/05 M Feldman

31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

ontrose Rd., Rockente MD 20852 32. Registrar's Stonature



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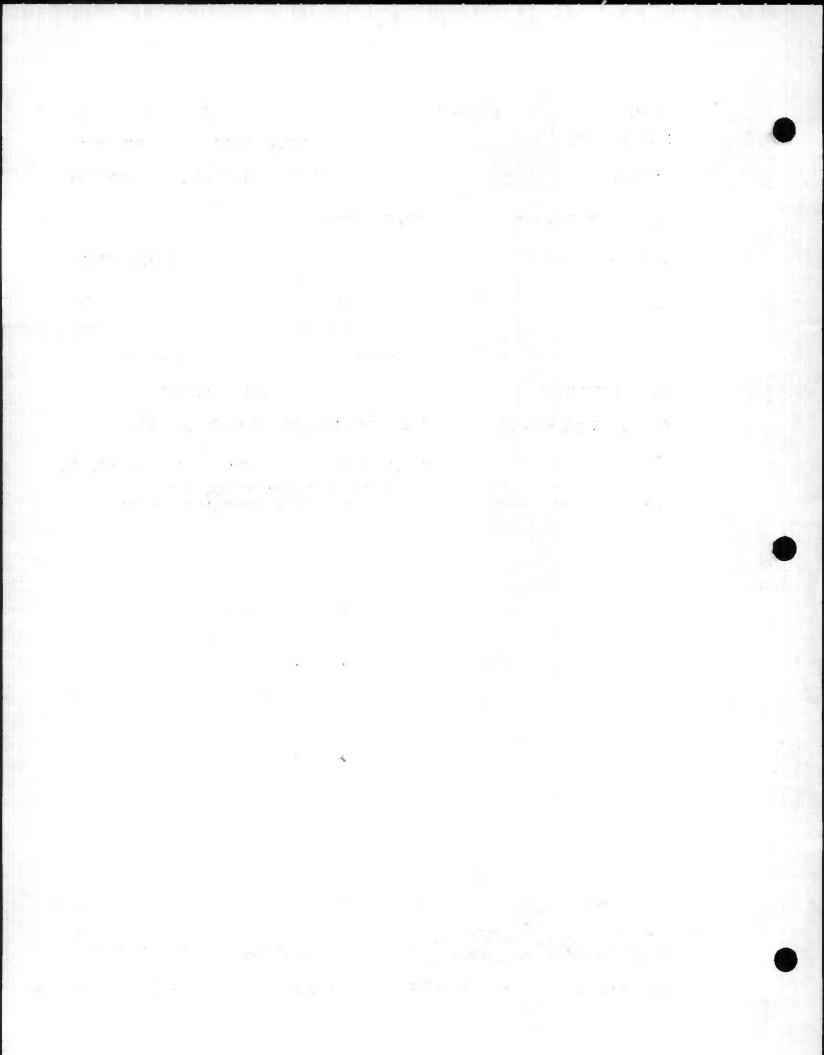
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth JUNE 1, Day 1998 **Physician** VIOLET RICHARDSON 1:00 PM /Medical 4a. Facility Neme (If not institution, give street and number)
FRIENDS NURSING HOME 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SANDY SPRING MONTGOMERY Hours Min. JUNE 24, 1904 5. Social Security Number If Under 1 Yeer 9. Birthplace (State or Foreign Country) MARYLAND 7. Age (In yrs. last birthdey) **Funeral** Months Deys 1□M 2⊠F 214 74 5622 93 Yrs **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other then "natural", or Nerna 23a or 28a-f show any Injury or other traumatic event, the Medical Exertinar mail be notified an angle. 10e. Stete 10d. tnside City Limits 10b. County 10c. City, Town or Location MD. MONTGOMERY SILVER SPRING 1 Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1704 EDNOR ROAD 20905 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritai Status 1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2. No WHITE Specify Specify: p 3 Widowed 4 □ Divorced Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) JOHN LETHBRIDGE ANNIE DISNEY 19e. Intorment's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN D. RICHARDSON, SON 1800 EDNOR ROAD, SILVER SPRING, MD. 20905 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e, Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 6/5/98 BURTONSVILLE, MD. UNION CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee MURIEL HOME FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete tntervel Between Onset end Death **Physician** HYPOSTATIC Immediete Cause (Final disease or condition resulting in deeth) /Medical Examiner Physiclan/Medical Examiner The law requires that the daath certificate be executed g physician and es the burial-transit Sequentielly list conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, es e consequence of): 1050LEROTIL CARDIOVASC. DS USB Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings avellable prior to completion of cause of deeth? 24a. Wes an autopsy certificate hes page 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piace of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA After this 27. Manner of Death

1 Natural

2 Accident 28d. Describe how injury occurred Certification: 5 Pending investigation 24 hours after death. Funeral Director: A 1 Yes 2 🗆 No 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Pieca of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and manner as stated.

Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piace, and due to the cause(s) end menner stated. 29e. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) de JUNE 1, 1998 30. Name end address of person who completed cause of deeth (item 23a) (Type, Print) 4000 RT108 OLNEY, MD 20832 MD LEWIS DONALD 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decodent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth BOLLMOR II Under 24 Hrs. 8. 9. AGE (In yrs. last birthday) MON Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Days Min 1 M 2 K 216-22-547 18 Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits Otimor 1 Yas 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5503 sta 21206 Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Stetus Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grade completed) Pharmacutical Elementary/Secondary (0-12) Collega (1-4or 5+) YRS d 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumame) Hollenbach dward 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Eldersburg, Md 21784 20c. Location - City or Town, State Margaret Strawbridge 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) June 1 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Mem. 4 □ Donation 5 □ Other (Specify) 1998 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licanses E. Vaus 23a. Part1. Enter the diseasa, or complications that caused tha deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one causa on each lina. Md 21234 Approximate Interval Between Onsat and Death Immediate Causa (Finel Rospiratory 2 hrs disease or condition resulting in death) a consequence of) DISEASE YEARS Due to (or as a consequence of): peardial Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown 24b. Wera autopsy findings available prior to 24e. Was an autopsy performed?

Physician /Medical **Examiner**

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7 is marked other than "naturel", or hems 23a or 28a-f shot traumatic event, the Medical Examiner must be notlined at

permit. Pagas 1 and 2 should be filed within 72 hours aftar daath 1 Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or Items 28 and Injury or other traumatic event, the Meg

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

the Maryland

with

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

completion of cause of death?

1 Yas 2 No 26. Placa of Deeth (Check only one)

1 Yes 225No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospitel:

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Placa of Injury · At homa, ferm, street, factory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Dete of Injury (Month, Day Year) 28c. injury et Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Cartifia (Check only one)

27. Manner of Deeth

1 Netural
2 Accident

3 Suicida

4 Homicide

1 🕰 Cartifying Physician: To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated.

29b. Signature and title of certified

29d. Date signed (Month, Dey, Year)

1 conec

5 Pending

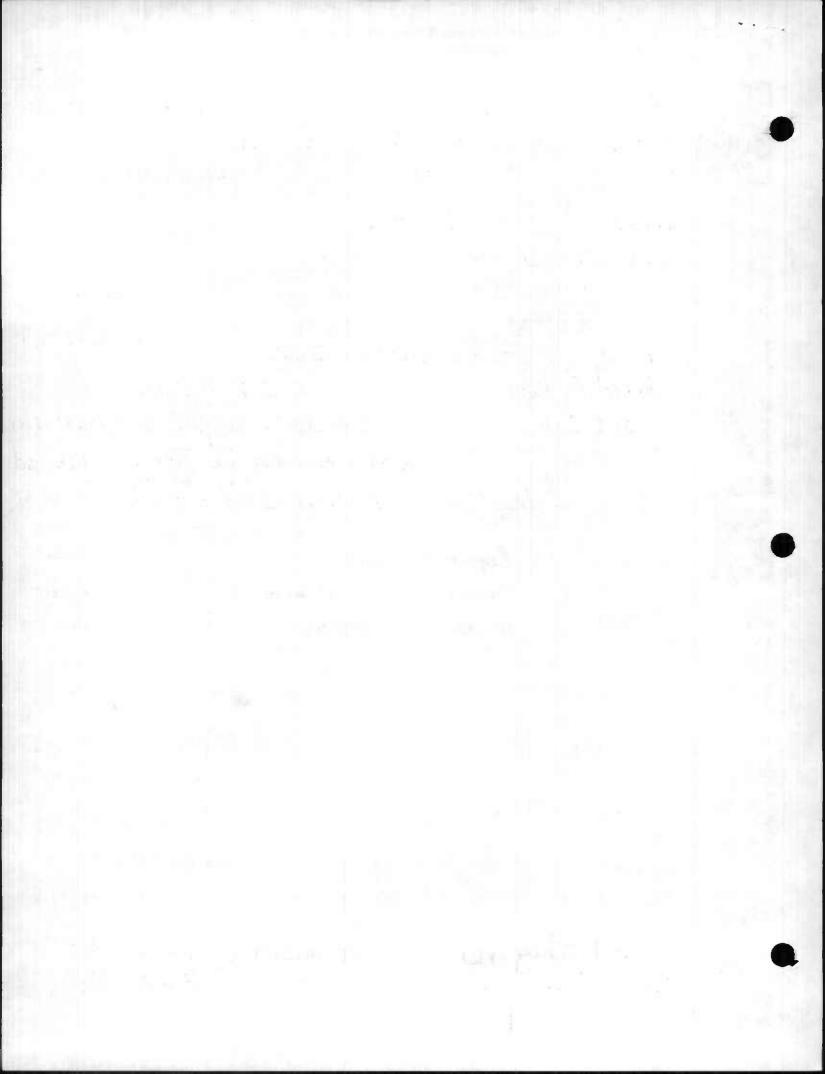
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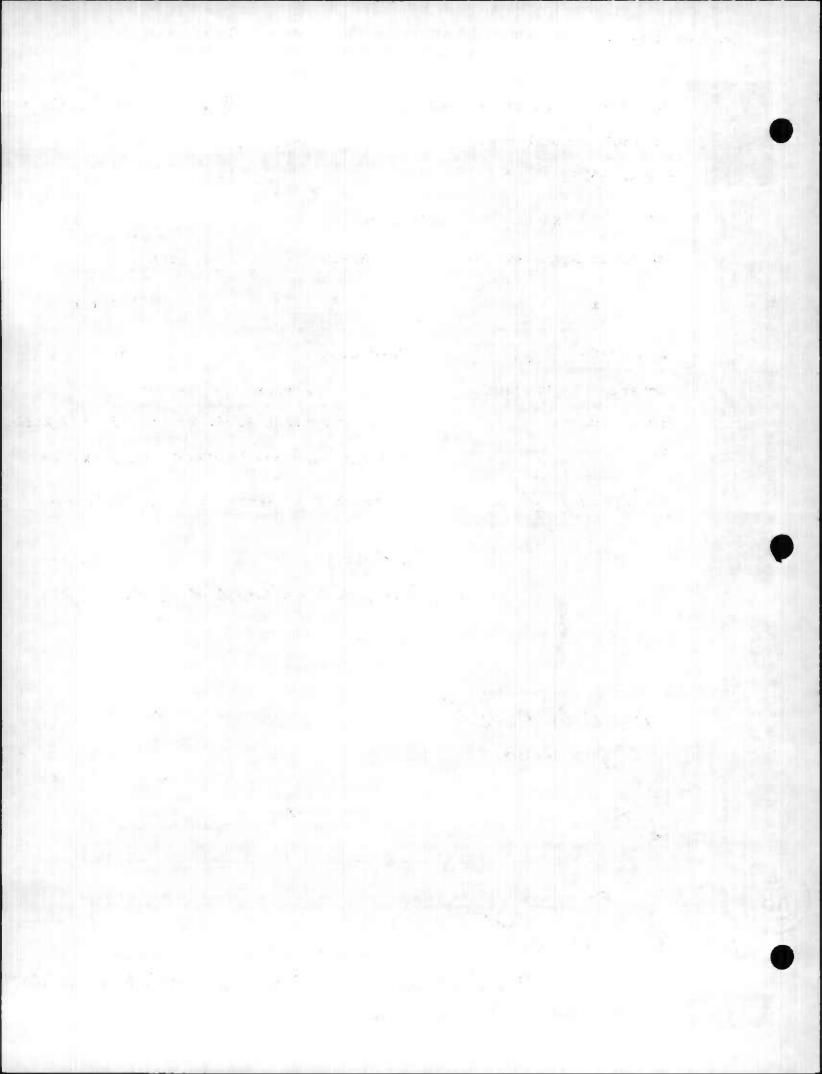
obe PY 1 one

31. Date filed (Month, Dey, Year) JUN 0 5 1998 32. Registrar's Signeture



Evaline Rogers Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State	of M	larylan				lealth a <i>Death</i>	ind M	lental Hyg	iene g	8 1	7440		
		1. Decedent's Name (First, Mide	tle, Last)								2. Date of Dea	th		3. Time of Death		
Physicia		Evaline	Flore	nce	Rog	jers					June	Dey 1	98	12:30 am		
/Medic Examin		4a Facility Name (If not institution	on, give street end	number,)				4b. City, Tov	wn, or Lo	cation of Deeth	4c. Cou	nty of Death			
AL .		Irvington K	noll N	н.					Balt			NA				
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐	_	ge (In yrs. l 70	ast birthday) Yrs.	If Unde Months	1 Year Days	H Under 2 Hours	Min.	8. Date of Birth (Month, Dey		9. Birth	plece (State or Foreign ntry)		
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or 28	Director	10e. Street and Number 10f. Zip Code									1	0g. Citizen	intry?			
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Physician		23a. Pert1. Enter the disease, of shock, or heart failure. List	st only one cause of	on each i	lne.								1	Interval Between Onset end Death		
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and	xan	Sequentially list conditions, if any, leading to immediate	quence of)					9								
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2 840 5	Certification:	4 Homicide	bi	uilding, e	tc. (Specity)				City or Tow	City or Town, Stete)					
Bary	-	29a. Certifier (Check only one) Certify	ing Physician: To I Examiner: On the	the best e basis of nanner st	of examinet	vledge, deat ion and/or in	h occurred vestigation	at the tir , in my c	me, date and opinion, deat	d place, th occurr	and due to the o	ause(s) and late and plac	menner as ce, and due	stated. to the cause(s)		
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7		30. Neme and address of person	who completed of	euse of	death (Item	23a) (Type.	Print)		170	19		~ .				
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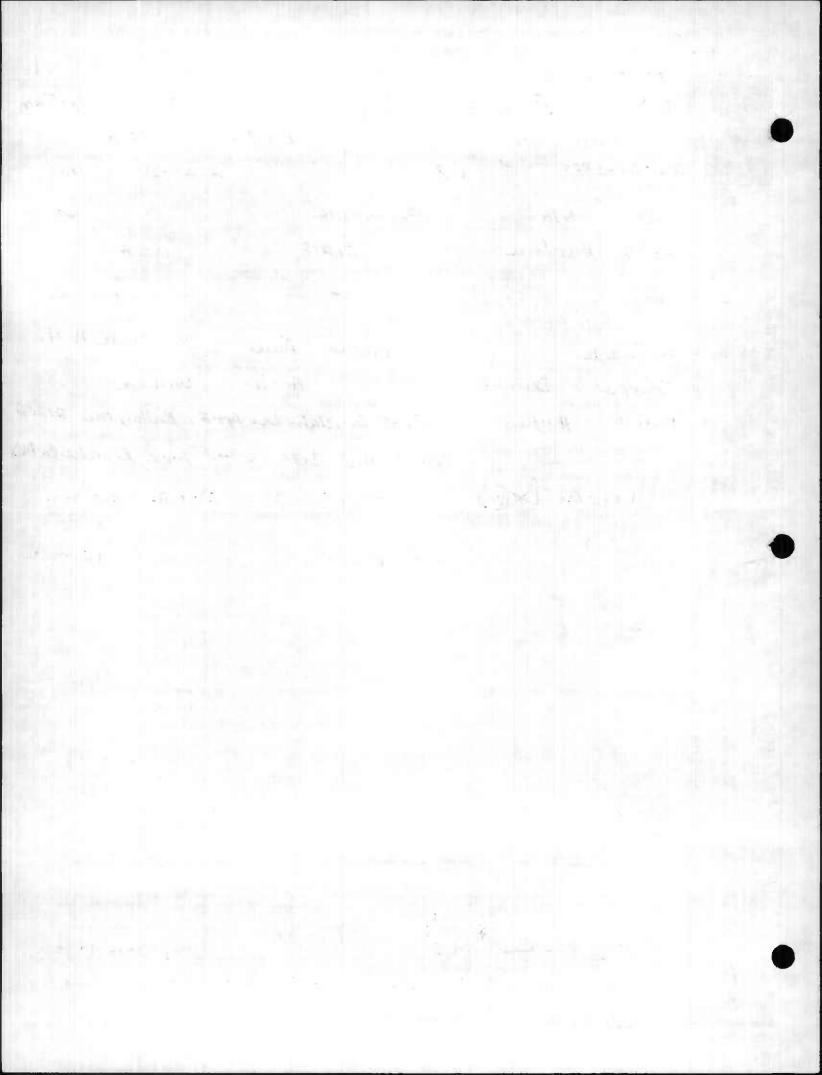


Esther Rav

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #1 Per MD Film G760 6-5-9880 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last Month **Physician** Bax 715 am Esther S S e aHINE /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Batto. 2309 Harford Rd. 8. Date of Birth (Month, Day, Year)
2-23-30 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys Hours Min 216-24-5832 68 Yrs. MD Director Usual Residence of Decedent death with the Maryland 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "nature!", or items 23a or 28a-f show other treumatic event, the Modical Examinet must be notified at NIA Baltimore 1 TYGS 2 No MD Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? Harford 21218 USA 2309 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 end 2 should be filed within 72 hours after onent of Health and Mantal Hygiane. Int: If Item 27 ie marked other than "naturel", or Itei 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Circle N. H. Key Flementary/Secondary (0-12) College (1-4or 5+) Dietary 9th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Williams Dunlap James 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Sinclair La. Apt 5, Batto., mD Parricia 5620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Anne Arundel Co, MD 1 Burlal 2 Cremation 3 Removal from State 6 permit. Pege Department of Important: If any injury or edar Hill 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signat re of Funeral Service License March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 10 months Cardiac disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last physician and the burial tran Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 189 981 signed by the a 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy paga 2 has 1 Yes 2 No 1 Yes 2 No cartificate or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Other (Specify) 1º 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending after death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m. 0 28th 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Huspital, 110 Tower, Bultimore, Maryland m.D. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Schie Sevidson JUN 0 5 1998

Registrar

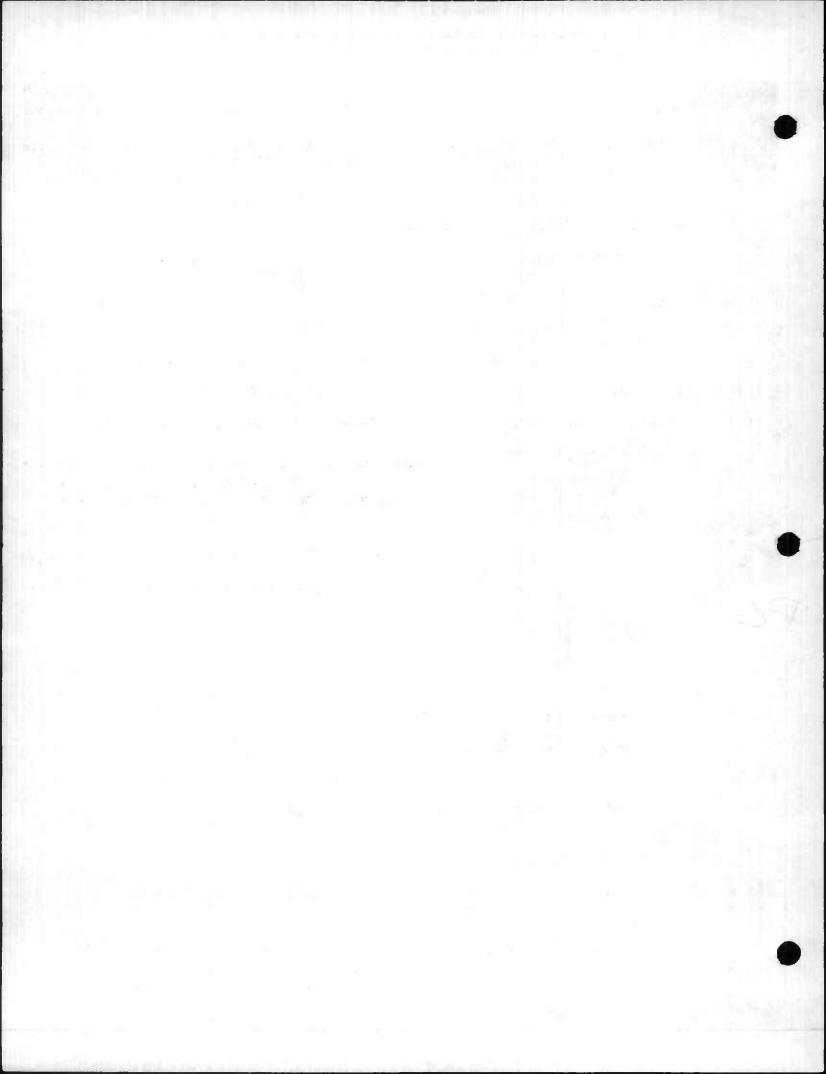


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth **Physician** Month RIGGIN SR. JUNE 1, 1998 9:15 AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HAMMONDS LANE CENTER GENESIS ELDERCARE BROOKLYN PARK ANNE ARUNDEL If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1**X**XM 2□ F Yrs. Director 218-03-6598 AUG. 7. 1903 MARYLAND Usuel Residence of Decadent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zlp Code 10a. Citizen of Whet Country? with 6214 N. ORCHARD ROAD permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiena. Important: if tem 27 is marked other than "retural", or items 23s any injury or other traumatic avant 21090 U.S.A. Funerai 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Memied Saltimore, Maryland 21215-0020 1 ☐ Yes 2√ No à Specify: WHITE 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) N/A CABINET MAKER CARPENTER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) HORACE RIGGIN 2 HENRIETTA HARDESTY 19e. informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUANITA F. SALA-DAUGHTER 2713 HARRINGTON RD. CHESTER, MARYLAND 21619 20b. Piece of Disposition (Neme of cometery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State GLEN HAVEN MEMORIAL PARK 6/4/98 GLEN BURNIE, MARYLAND 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, only one cause on each line. **Physician** e. Congestive Aeart Failure severes months /Medical Immediete Ceuse (Finel disease or condition resulting in death) Examiner fic Heart Disease Examiner Sequentielly list conditions, if eny, leading to Immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Box 68760. Physician/Medical å Due to (or as e consequence of) atten Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the cause of deeth? Division of Vital Records, P.O. 2 Chronic Renal signed by Failure 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings eveileble prior to completion of cause of death? Hip Fracture 24e. Wes en eutopsy performed? Completed 報 page 2 certificate 1 Yes 2₽No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical exeminar? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ ř 27. Manner of Deeth 28e. Deta of Injury (Month, Dev Year) 28b. Time of 28d. Dascribe how Injury occurred Certification: 28c. Injury et Work? Affair 1 Neturel 5 Panding invastigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Thomleida 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date end place, end due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 101459 30. Name and addrass of person who complated causa of daath (Itam 23a) (Type, Print) COLVIN C. CARTER, MD 4760 Penning tun Aul. Baltimore Muryland 31. Date filed (Month, Day, Yaar) 32. Registrer's Signeture State JUN Q 5 1998 Excha Devidon Handale Registrar



Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amend: #26 Per MD Film G760 6-5-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** 27, 1998 Jaron 101 6:05 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** 1535 WOODBOURNE AVE BALTO N/AIf Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Days Hours Min 1 M 2 KF Yrs. 48 216-52-9020 JAN23, 1950 MD Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 TYes 2 □ No MD N/A Director BALTO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4717 SHAMROCK AVE U.S.A. Funerai 21206 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 20 No if Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Maritel Status Bleck, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede comp completed) College (1-4or 5+) Elementary/Secondery (0-12) DOCTORS OFFICE SECRETARY 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be GEORGE SOLOMON DELORES BROWN 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) LARRY REDMOND/HUSBAND 4717 SHAMROCK AVE BALTO, MD 21206 20b. Place of Disposition (Name of cemetery, cremetory or other place) GAR Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from State 6-2-98 TIMONIUM, MD DULANEY VALLEY MEM 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility BETTS FUNERAL HM 21. Signature of Juneral Service Licensee 1129 N. CAROLINE ST BALTO, MD 21213 1010 23a. Part1. En er the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Nonsmall Gel) Ling Cancer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings evelleble prior to completion of cause of death? Completed 24e. Wes en eutopsy 1 ☐ Yes 2 No 1 Yes 2 No DAUGHTER'S 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one)

Physician /Medical Examiner

permit. Page Department of Important: If any injury or once.

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23s or 28s-f show ary or other traumetic event, the Medical Examination and the notified at

Baltimore, Maryland 21215-0020

physician and the burial-transit 98 attanding p signed by the a s certificata has b director, page 2 s director, 2

requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Hospital or Attending Physician: After this funerei death. after deati Director:

To the Hospi within 24 hou To the Funer completely fill

filled in t hours a 24 hours

Hospital: Other: 4 Nursing Home 3 Tesidense 8 Other (Specify) HOME 1□ Yes 2No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 Yes 2 🗆 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29b. Signeture and title of certifier allend

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dav. Year) 29c. License number

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ETTINGER DAVID S The JOHNSHOP

JUN 0 5 1998

)NCO/any Center

98

State Registrar

Certification:

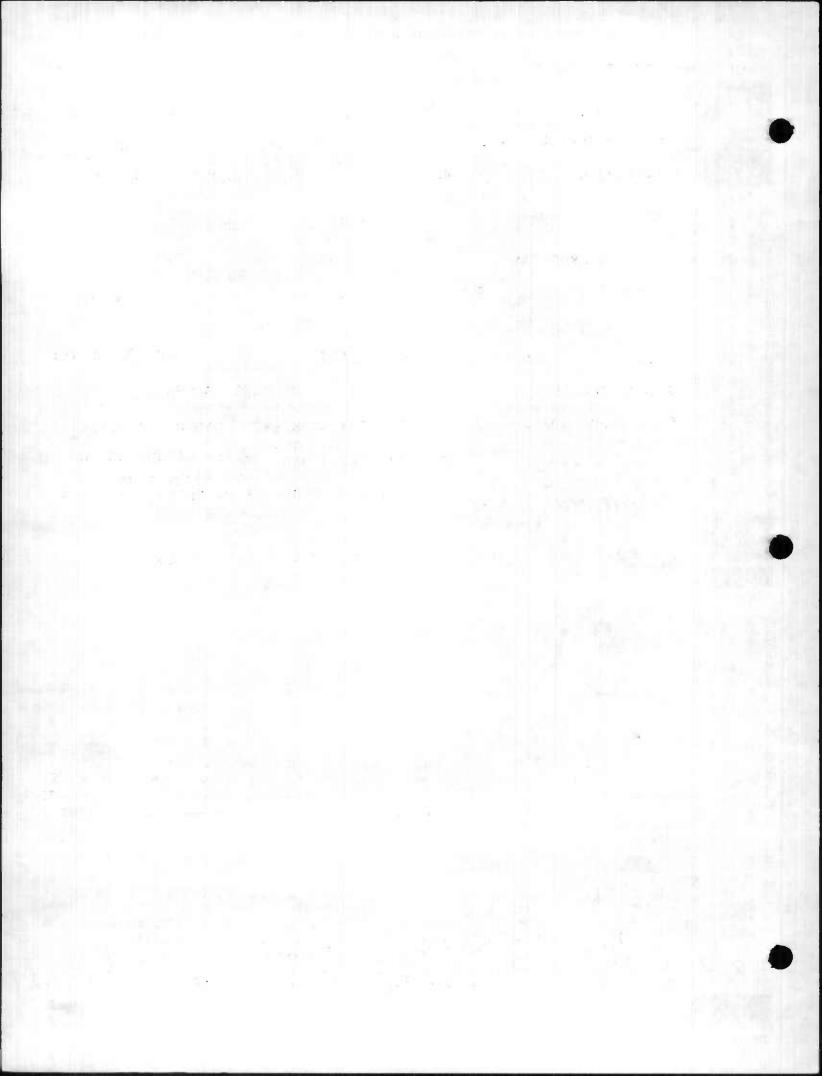
edical

29a. Certifier

31. Date filed (Month, Dey, Year)

32. Registra's Signature

Fulia Davidon Randese



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Vernon Henry Riemenschneider 104 3/ /Medical 4e. Facility Name (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Beeth **Examiner** Fallston General Hospital Fallston Harford 6. Sex 1 Ø M 2 ☐ F If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Yrs. Director 215-16-2720 Mar, 31, 1920 Baltimore Co. Md Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits worle 7 is marked other than "natural", or items 23a or 28a-f ebov traumatic event, the Modical Examinating that be notified at 1 Yes 2 No Directo Maryland Harford Forest Hill 10f. Zip Code 10g. Citizen of What Country? 314 Whetstone Road 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Haatth and Mental Hygiane. Int: If item 27 is marked other than "natural", or iter any or other traumatic event, it a Medical Example. Black, White, etc. Nimed Forces? 1 (X) Yes 2 \sum No 5/15/ If Yes, Give Yeer or Dates 2/18/46 1 Never Merried 2 Married 1 ☐ Yes 2 💢 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 12 yrs. n/a Carpenter Gordon Smith & Co. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Charles Riemenschneider Mamie Weinreich 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Gerden Riemenschneider (Son) 11909 Crestwood Circle Waynesboro, PA. 17268 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) BelAir Memorial Gardens 6/4/98 BelAir, Md. 21014 21. Signature of Funeral Service Licens 22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087 23e. Pert 1. Enter the disease, or corp lications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical OSTATE CAUCER Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use coptribute to the ceuse of death? 1 Yes 2000 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? 2 No 1 Yes 2 No certificate 25. Wes case referred to mudical examiner? 8 26. Place of Death (Check only one) 2[9 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 1 (1) Inpatient 2 ER/Outpatient 3 DOA 414 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 PNatural 1 ☐ Yes 2 ☐ No 2 Accident Director Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Within 2 To the

le menschneider,

21215-0020

Maryland

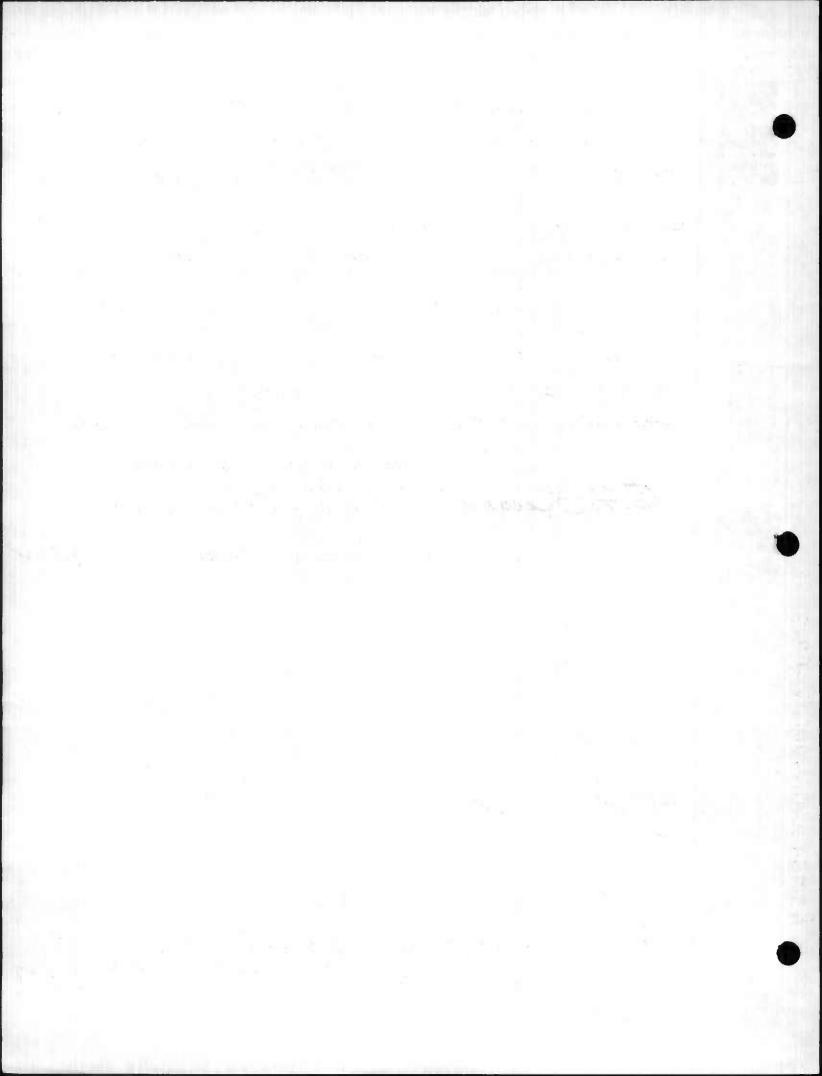
Baltimore,

31. Date filed (Month, Day, Year) State Registrar

255. Signature and title of certifier

32. Registrar's Signature whice Davidson

pleted cause of deeth (Item 23e) (Type, Print)



Physician/Medical the signed by by Completed certificate hes Be To Certification: To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A

Division of Vital Records.

death.

art II. Other significant conditions o	ontributing to death but not res	sulting In tha und	arlying	caus	a givan In Part I.	23b. Did tobacco ues 1 🗆 Yes 2 🗆 No	contribute to the cause of death? 3 Probably 4 Prunknown			
						24a. Was an autopsy performed?	24b. Wara autopsy findings aveilabla prior to completion of cause of daath?			
25. Was casa rafarred to medical					36 Place of D	Path (Check only one)	Yas 2□ No			
examiner? XXYas 2□ No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ □	g Home 5 ☐ Rasidenca 6 ☐ Othar (Specify)						
7. Manner of Death 1 □ Natural 5 □ Pending XXX Accident Investigatio	28a. Data of Injury (Month, Day Year) 5/30/98	28b. Time of Injury 3:15	Р		Injury at Work? 1 ☐ Yas 2 X No	28d. Dascribe how injury occurred Subject found in closed car				
3 ☐ Suicida 6 ☐ Could not be datarmined			t, facto	ry, of	28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 10702 Clinton Ave. Hagerstown, Washington Co., Md.					

3. Time of Death

1607 PM

1 ☐ Yes 2 No

Approximate Interval Batween Onsat and Daath

29d. Data signed (Month, Day, Year)

MAY 31, 1998

State Registrar

edical

29b. Signatu

molxon 31. Data filed (Yonth, Day, Year

and title of cartifie

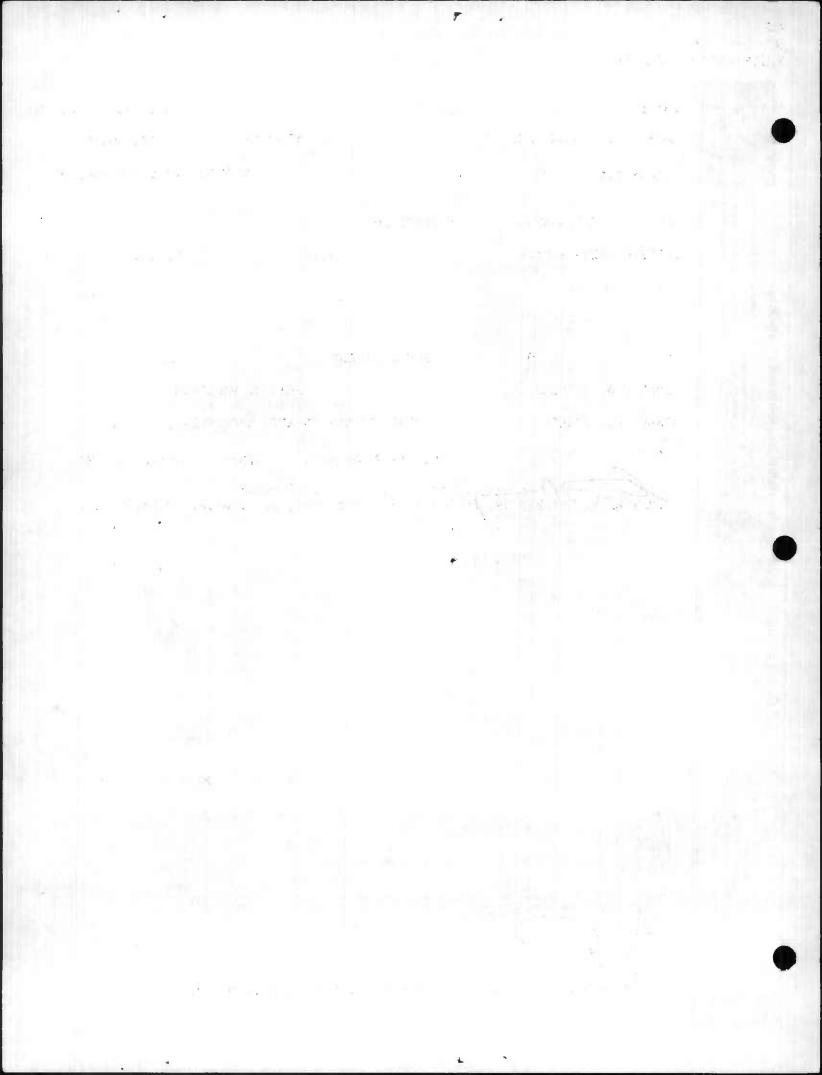
amaiwa. w Day son

stress of person who complated causa of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

OCME

29c. License number



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 446 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** WILLIAM 4:05 n.m. CARL SCHWARTZ May 30, 1998 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore if Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foraign Country) **Funeral** 1₽M 2□F Months Yrs. 151-30-7746 Director June 18, 1938 New Jersey Usual Residence of Decadent 10e State 10h Counts 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the Maryles nant of Health and Mentel Hyglena.
ant: If Item 27 Ie marked other than "natural; or Items 23a or 28a-f show ury or other traumatic event, the Medical Example must be notified at 1 ☐ Yes 2 ♥ No Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Gunview Farm Court 21128 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yas 2 □ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Biack, White, etc. 1 Nevar Married 2 Married 1 Yes 2♥ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) 5+ years Electrical Engineer Defense Department 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) William Schwartz Elizabeth Kautter 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joyce Schwartz (wife) 13 Gunview Farm Court Perry Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of Important: If it any injury or c 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 6-1-98 Pikesville, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Home, Inc. 21. Signature of Funeral Service Licenses 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1-0 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a. Hypoxic Encephalopathy
Due to (or es a consequence of): 6 Days Examiner Examiner 8 Days Accident Cerebral Vascular physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of) signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to should s 24a. Was an autopsy performed? Completed completion of cause of death? s cartificate hes b 2 N No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3□ DOA sid. funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28h Time of 28c. Injury et Work? Certification: 28e. Date of Injury (Month, Dev Year) After 5 Pending investigation Neturel 1 Yes 2 No after deeth.

Director: A 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours aft the Funeral Di mpletaly filled in 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) edical and manner stated. To the I within 2 To the I comple

C

Villiam

Schwartz

Baltimore,

The law requires that the deeth certificate be executed

or Attending Physician:

Hospital

deeth.

Division of Vital Records, P.O. Box 68760,

deeth with the Marylend

State Registrar

Dawn Warner 31. Date filed (Month, Day, Year) JUN 0 5 1998

29b. Signature and title of certified

M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237 32. Registrar's Signature

worner

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

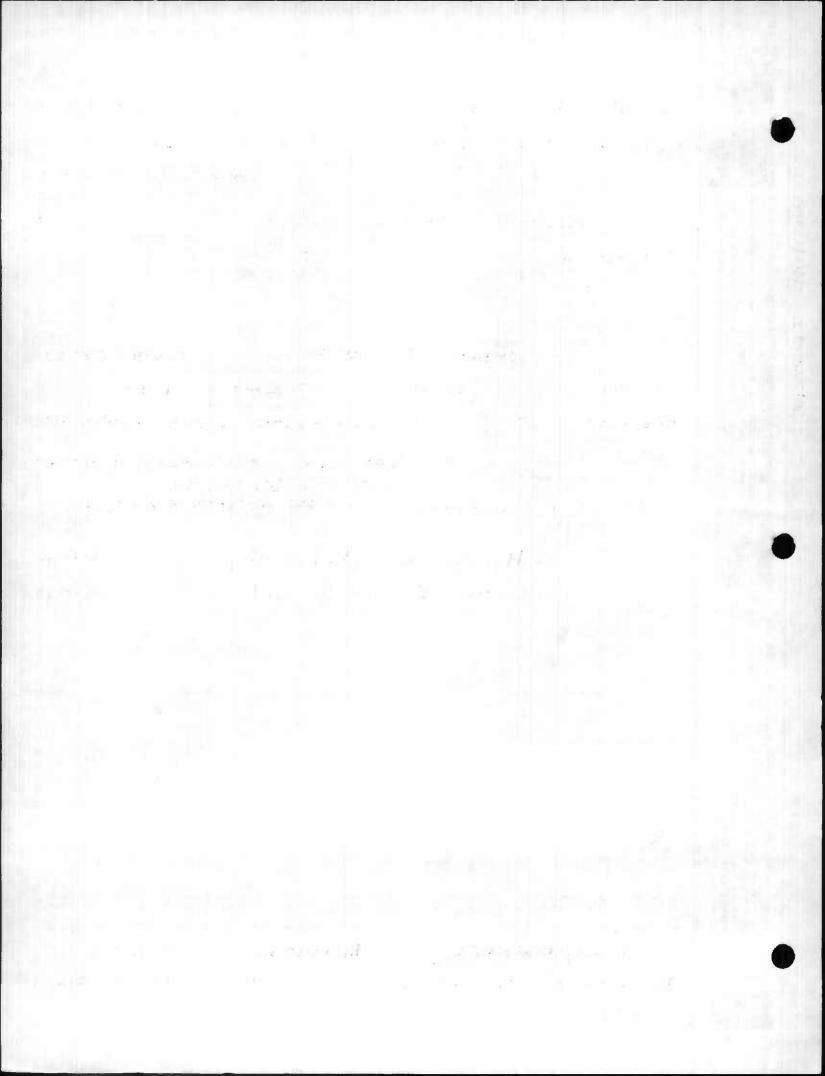
Jilia Davidson Bandoca

29c. Licansa number

RD 187252

29d. Data signed (Month, Day, Year)

5/30/1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 1998 JEROME B. SMITH 0415 3 June /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner ST. Agnes Hospital Baltimore md NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys 1 € M 2 □ F Months Yrs. Director 217-16-6425 MARYLAND JAN 10,1924 Usual Residence of Decedent with the Maryland r 28a-f ahow a notified at 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inaide City Limits 1 ☐ Yes 2 € No ector BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death within Department of Haalth and Mental Hygiana.
Important: If item 27 is marked other than "natural", or itema 23a or any injury or other treumatic event, the Medical Examiner man be nonce. 눕 1041 ELM ROAD 21227 Funeral I.S.A. 14. Race - American Indian, 12. Wes Decedent Ever in U.S. Armed Forces? 1♥1 Yes 2□No If Yes, Give Year or Dates: WW II Wes Decedent of Hispento Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced WHITE Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) AAI DEFENSE CONTRACTOR 11TH GRADE WELDER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) PAUL T. SMITH, SR GENEVIEVE KAIRAS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHY POETSCHAN (DAUGHTER) 1041 ELM ROAD - BALTIMORE, MD 21227 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Runiel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST VETS CEM 6/8/98 OWINGS MILLS, MD 22. Name end Address of Fecility
HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD the disease, or complications that cause eart failure. List only one cause on each Approximete Intervel Between Onset end Deeth Do not enter the mode of dying, such as cardiac or respiratory ar **Physician** /Medical Immediate Cause (Final · Aspiration 16 hours diseese or condition resulting in death) Examiner Examiner Cerebral Vasculitie 6 weeks attending physicien and for use as the buriel-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): Records. P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Smith signed by t 3 Probably 4 Unknown 1 ☐ Yae 2 ☐ No Pertinson's discase þ 24b. Were autopsy findings aveileble prior to Completed 24e. Wes en autopsy performed? chronic obstructive Pulmonery disease completion of cause of death? s certificata has b 1 Yes 2 No 1 Yes 2 No or Attending Physician: director Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Jerome Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After Injury 1 Neturel 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) To the P within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Bany Ligeron M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) June 3, 1997 10881

900 caton AVE Baltimore md 21229

he Burdson-Randell

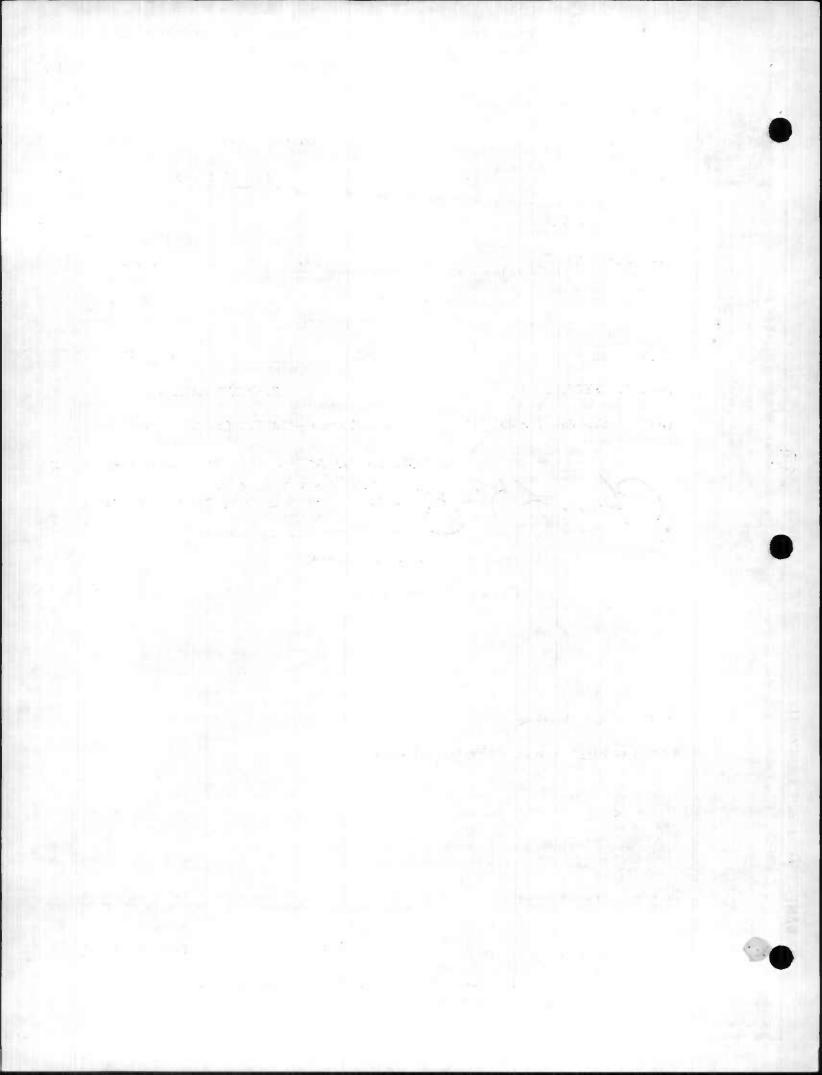
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Barry Liberoni 31. Dete filed (Month, Day, Year)
JUN 0 5 1998

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print In Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Spirko 4 p.m. Andrew June 4, 1998 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Carroll 125 Lassiter Circle Finksburg 6. Date of Birth

Month, Day, Year Pennsylvania

9. Birthplace (Stere G. 19)

Country)

Pennsylvania 5. Social Security Number if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 75 Yrs. Director 184-18-1022 Usuel Residence of Deceden the Meryland 10d. Inside City Limits 10a State 10h Count 10c. City, Town or Location 7 is marked other than "natural", or ftems 23s or 28s-f show traumatic event, its Medical Examinar must be notified at Finksburg 1 Yes 2 No Carroll Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21048 U.S.A. 125 Lassiter Circle Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Maritel Stetus Bleck, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, its Medical Exercises once. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Mass Transit Authorit Elementary/Secondary (0-12) Chauffer 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Jacob Spirko Mary Spirko 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Margaret Spirko - Wife 125 Lassiter Circle, Finksburg, Md. 21048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State June 8, 1998 Woodlawn, Md. Lorraine Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service License 22. Name and Address of Facility
Eckhardt Funeral Chapel 21117 23a. Part1. Enter 17 disease, or complications that caused the deeth. Do not enter the mode of dyling, such as cardiac or respiretory arrest, Approximate shock, or help failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner estre physician end the buriel-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): certificate be execu phy leng Box 68760. Physician/Medical USB 0 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? P.0. 3 disease. 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. 2 8 24b. Were autopsy findings avellable prior to 24a. Was an autopsy performed? Completed completion of cause of death? has 1 ☐ Yes 2 ZNo 1 ☐ Yes 2 🕱 No Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 PResidence 6 Other (Specify) To 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: Attending 1 Natural 5 Pending aftar death. Director: Aft 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 0 30 33 9 29d. Dete signed (Month, Day, Year) 29b. Signature and little of certifier

State Registrar Date filed (Month Day Year)

and address of person



Const Road; Baltimore

who completed cause of death (Item 23a) (Type, Print)

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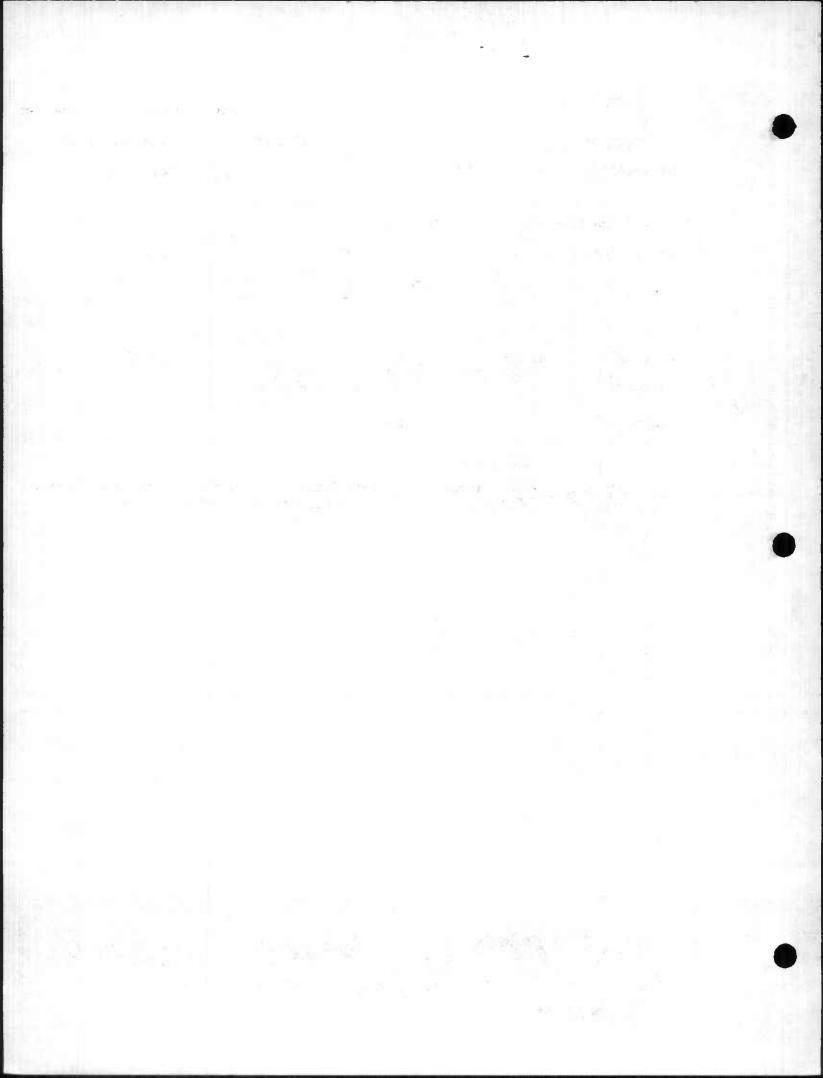
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

								Certi	ificate o	f Death			Reg. No.	1 /	449	
	Physici /Medi		David Smith Aa. Facility Nama (if not institution, give street and number) MERCY HOSPITAL									2. Data of De Month May 9	eath Day	Yaar	3. Tima of Death 10:42 AM	
	Examir									4b. City, To		ation of Deat	h 4c. Count	4c. County of Death BALTIMORE CITY		
	Funeral Director		5. Social Security Number 220-36-6250	6. S	ex ☑M 2□F	7. Aga (In yrs 57			If Under 1 Ya Months Da		24 Hrs. Min.	8. Data of Bir (Month, De OV . 4,	th ly, Year) 1940	9. Birthplac Country unkno	ca (Stata or Foreign y))WN	
	pur &		Usual Rasidance of Daced 10a. Stata 10b. C			100.0	ity, Town	or Loca	tion					100	d Incide Ohy I India	
ore,	e Maryle	ctor	Maryland Bal	ltim		tion						d. Inside City Limits 1				
	h with th	al Director											13			
	be filed within 72 hours after death with the Maryland nat Hygiene. d other than "natural", or items 23a or 28a-f show event, in Medical Examinet must be notified at	by Funeral	11. Marital Status 1 □XVavar Married 2 □ 3 □ Widowed 4 □ Div		12. Was Decedant Evar in U,S. Armed Forcas? Unknown 1 □ Yas 2 □ No If Yas, Giva Yaar or Datas: 13. Was Dacedant of If Yas, Specify C				uban, Maxica	n, Puarto P	cify Yas or No lican, atc.)	Bie	14. Race - American Indian, Black, White, atc. Specify: Black			
	filed within 72 ho Hygiene. other than "naturent, the Medical	Completed	15. De (Specify only Elamentary/Secondary (t unknown	0-12)	ucation da complatad) Collega (1-4or 5+) unknown 16a. Decer (Giva iiia. u					cupation na <i>during mos</i> <i>ired</i>)	st of workin	16b. Kind of Businass/Industry unknown			stry	
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	and 2 should ealth and Mer n 27 is merke her traumatic										er or Rural	ral Routa Number, City or Town, State, Zip Code)				
	permit. Pages 1 and 2 Department of Health of Important: If Item 27 is any injury or other tre office.		20a. Mathod of Disposition 1 Burial 2 Cram 4 Donation 5 Dot	ation 3 🗆	Ramoval from	Stata	Pleca of camatar	Disposit y, crama	ion (Nama of tory or othar p	olace)	1	Data	20c. Location	- City or Town	n, Stata	
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68/60,	certificate be executed rding physician and use as the burial-transit	al Examiner	Sequantially list conditions if any, laading to immadiat cause. Entar Undarfying Cause (Disease or Injury that initiated events	\{	b. — Dua to (or as a consequence of):											
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0	hyse his c	2	Yas 2□ No				ER/Out	tpatient	3LI DOA		ursing Hom	a 5□ Rasi	dence 8 □Ot	har (Specify)		
	or Attending Physiater death. Director: After this in by the funeral di	atlon:		anding nvastigation		of Injury oth, Day Year)	28b. T	ima of njury	28c. lr V M 1	njuryat Vork? □Yas 2□		8d. Dascribe	how Injury occu	med		
DIVISION	al or Attending F s after death. Il Director: After ed in by the funer	Certification:	3 Sulcide 6 0 4 Homicide	Could not be latarmined	288. Piec	e of Injury - At I ing, atc. (Spec		m, stree	t, fectory, offic	20	2	Bf. Location (City or To	Street and Num wn, Stata)	ber or Rural F	Routa Number,	
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	To the To the Comp	X	29b. Signature and title of o	ertifiar	1 1	10			29c. Lice	ensa number	240		29d. Data signi	ed (Month, Da	ly, Year)	

State Registrar Data filed (Month, Day, Year)

32. Registres signature Pandall

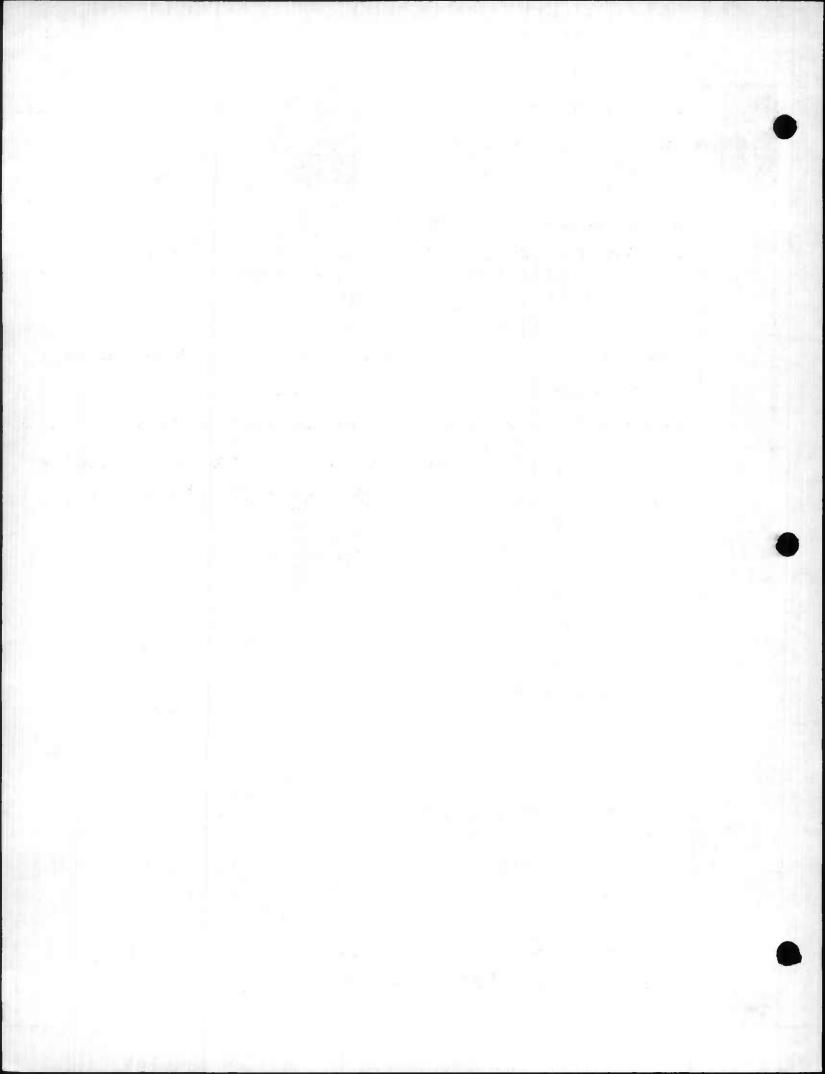


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month June 3, JOHN E. SATTERFIELD 7:00 a.m. /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3502 Thomas Pointe Court, Apt. 2A Abingdon Har ord 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Sociel Security Number 6. Sex Birthplaca (Stete or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 219-12-7395 Yrs Director Feb. 16. 1924 Maryland Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tem 27 is marked other than *naturel; or items 23s or 28a-f show other traumatic event, the Madical Examiner man be not fed at 1 ☐ Yes 2 No Director Maryland Harford Abingdon 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 3502 Thomas Pointe Court, Apt. 2A 21009 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mentel Hygiene.
Important: if them 27 is marked other than "naturel", or items any injury or other traumatic event 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispento Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indien, Black, White, etc. 1 XYas 2 No If Yes, Give Yaar or Dates: 1946-47 1 ☐ Naver Merried 2 ☑ Married Baltimore, Maryland 21215-0020 þ Specify. 3 ☐ Widowed 4 ☐ Divorcad White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coltege (1-4or 5+) 10th grade Assistant Manager Retail Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Francis Satterfield Alice Berkley 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3502 Thomas Pointe Court, Apt. 2A, Abingdon, MD. 21009 Lorraine M. Satterfield (Wife) 20e. Mathod of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery 7/7/98 Baltimore, Maryland 21. Signeture of Funeral Service Licanses 22. Name and Address of Facility 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feliure. List only one cause on each line. Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21 Approximete tntervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final SMALL CELL CARENOMS disease or condition resulting in deeth) Lyeurs Examiner Examiner requires that the death certificeta be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last and Due to (or es a consequença of) ettending physician for use as the buria Box 68760. Physician/Medical Due to (or es e consequença of) signed by the 6 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed cartificate 1 ☐ Yes 20 No 1 Yes 20 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cartifict completaly filled in by the funeral director, i 25. Wes case reterred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home ATResidenca 8 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Yeer) 28b. Time of 28d. Describe how tnjury occurred 28c. Injury et Work? 5 Pending invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pieca of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29e. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end mennar stated. 29b. Signature end title of cartifian 29c. Licanse number 29d. Date signed (Month, Dey, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 7672 Byloin 31. Dete filed (Mon 32. Registrar's Signeture State Julia Davidson Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Deeth SHANHOLT 19/Am EVA Month 05 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore County Manor Care Nursing Home 8. Data of Birth (Month, Day, Year) Feb. 16,1905 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthpleca (Stata or Foreign 1□M 20 F Deys Hours 93 Yrs 213-36-0614 Virginia Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 XNo Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3129 Parktowne Road 21234 U.S.A. 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 11 Marital Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2X No Specify: Specify: 3 N Widowad 4 Divorced White 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home Year 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumame) Williams Willie Phrryus Ε. Winters 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Streat end Number or Rural Route Number, City or Town, Stete, Zip Coda) Frances M. Maisenhalder/Daughter 3129 Parktowne Road, Baltimore, Maryland 21234 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 6/5/98 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signature of Funday Service Licensee 22. Nama and Addrass of Facility John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 tha death. Do not entar the mode of dying, such es cerdiac or respiratory arrest, Myocardial Infarction Immediate Causa (Final diseasa or condition resulting in death) Sequentially list conditions, if eny, laeding to immedieta ceuse. Enter Underlying Causa (Disease or tripiry that Initiated avants rasulting in death) Last Due to (or as a consequence of) Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Wara autopsy findings available prior to 24e. Wes an autopsy performed? completion of ceuse of death? 1 Yas 2 NO 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Place of Deeth (Chack only one) Othar: 1 Yas 2 No Wursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

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permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiens. Important: If item 27 is marked other than eny injury or other traumatic event.

Director

Funerai

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Completed

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traumatic event, the Medical Examiner nast be notified at

the Maryland

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Completed by certificata has Be 2 this After daath. Director: / aftar

P.O. Box 6878 Records, of Vital or Attending Physician: Division Hospital

To the Hospital within 24 hours a To the Funeral Completely filled Medicai

> State Registrar

29b. Signetura and tilla of certilian

5 Panding investigation

6 Coutd not be datamined

28a. Data of Injury (Month, Day Year)

28c. Injury at Work?

1 🗌 Yes

2 No

1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, data and plece, end due to the cause(s) and manner as steted.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

281. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how Injury occurred

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

AH. GHILADI, MD. 7600 OSLER Dr. Towson, Md. 2/204

31. Data fited (Month, Day, Year) JUN 0 5 1998

27. Mannar of Death

1 Naturat 2 Accident

3 Suicide

29a. Cartifiar

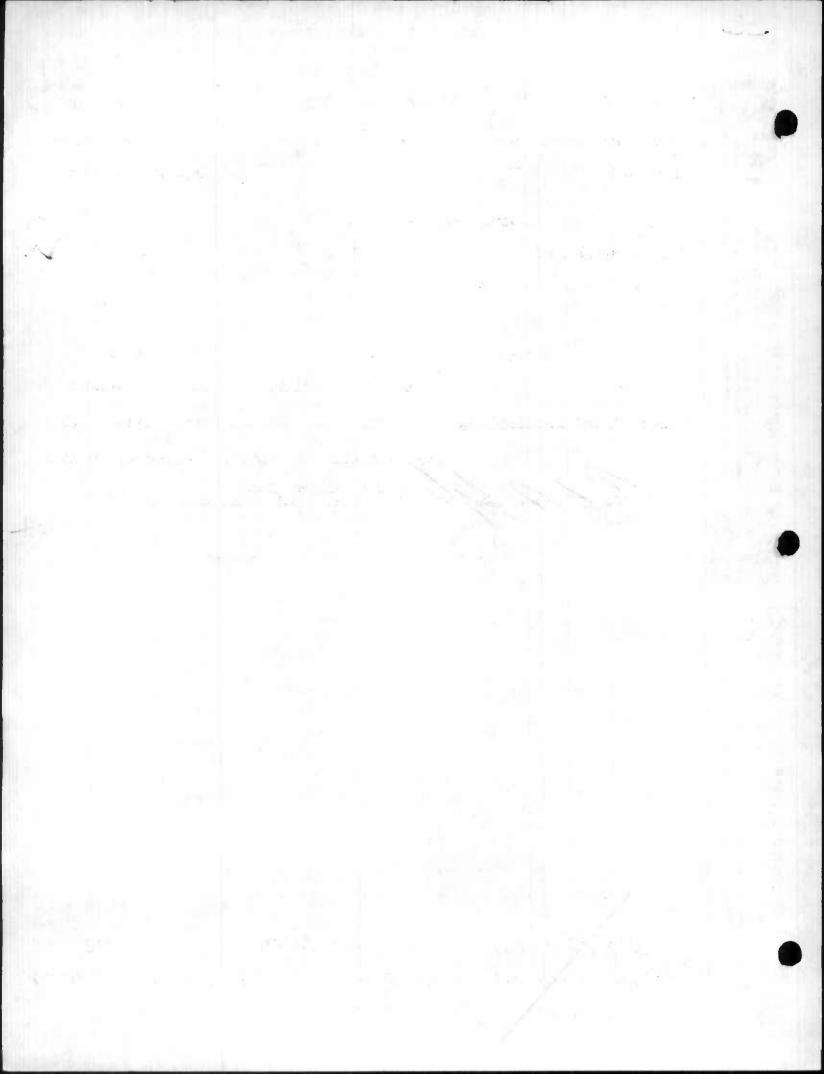
4 Homlcida

(Check only one)

32. Ragistra's Signature
Fund Davidson-Randell

28b. Tima of

28a. Place of Injury - At homa, farm, streat, fectory, office building, atc. (Spacify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** 8:10 P.M nomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, giva street and number) Examiner Sandtown NA Baltimore Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Months 10 M 2□ F 64-8413 **Director** -5 Usuel Residence of Decedent the Maryland 10a. Stete 10c. City, Town or Location 10d. Insida City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Md Baltimore 1 Yes 2 No Director NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21229 tartem Hvenue SA Funerai 1 permit. Pages 1 and 2 should be filled within 72 hours after death. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23 eny injury or other treumstic event, the Medical Examples must 12. Was Decedant Evar In U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specity: Black 1 Yas 2 No Specify: altimore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) Elementary/Secondery (0-12)
Ith gradl College (1-4or 5+) Unknown Unknown NA 17. Eather's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) Be Benjamin Wiggins 2 oan pscomb Jeforment's Neme/Rejetionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Wiggins 20b. Plece of Disposition (Name of cemetery, crematory or other place) Ba Ho, red Mother 21229 em 20c. Locetion - City or Town, Stete 20e. Method of Disposition Dele Burial 2 ☐ Cremation 3 ☐ Removal from State ar em MA 4 □ Donation 5 □ Other (Specify) 1/10 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility 300 wabash a A 23a Part1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arreat, ahock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disaese or condition resulting in death) VIRAL O. ITUMPA 1 MAUNUMATEL CHALL Examiner Due to (or es e consequence of): IMPRICTION e Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medical the state Due to (or es e consequence of) Ę attending Part II. Other significant conditions contributing to deeth but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 3 1 ☐ Yee 2 ☐ No 3 □ Probably 4 □ Unknown signed t þ 24b. Were eutopay findings aveilable prior to Completed 24e. Wes en eutopsy completion of causa of death? page 2 1 ☐ Yes 2 ☐ No 1 Yes certificate Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was cese referred to medical examiner? director, Be 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 MG 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Accident 5 Pending Investigetion 1 Yes 2 No filled in by the 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel C Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es stated.

2 Medicat Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the time, date and place, end dua to tha causa(s) end menner steted. edicai 29a. Certifier 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and the of certifier

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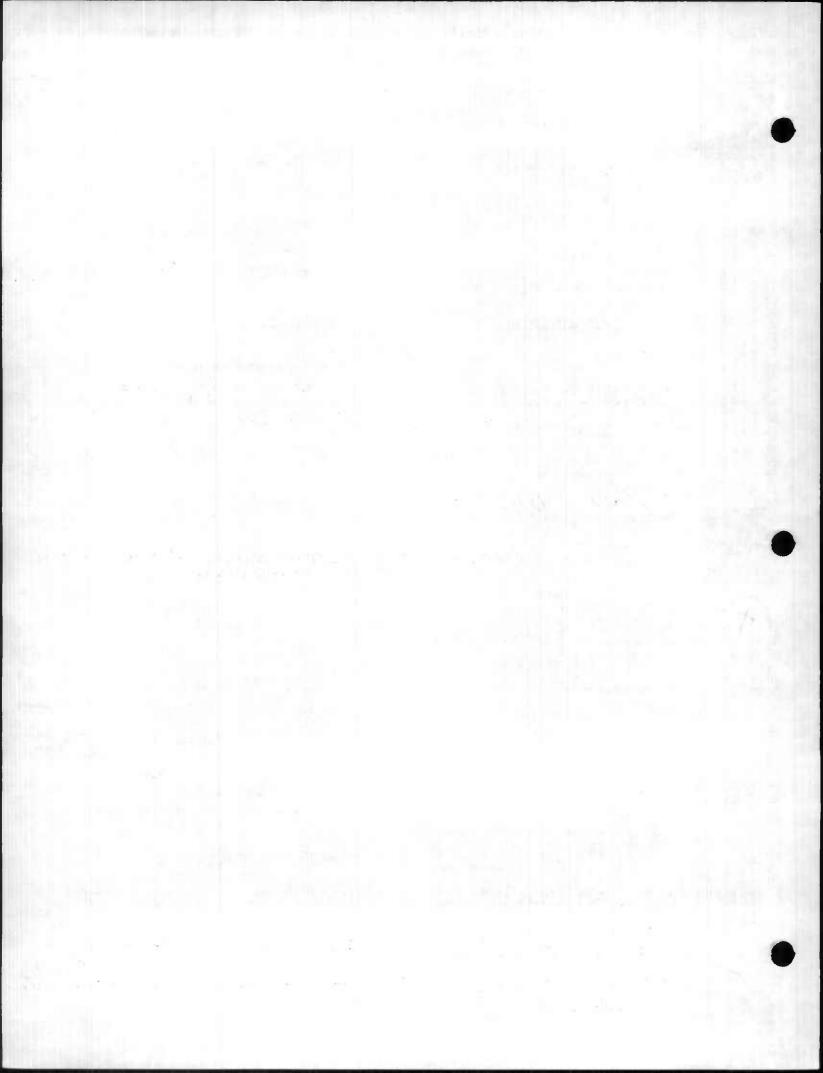
LINITHOUD, MA

d eddress of person who completed cause of death (Item 23a) (Type, Print)

SHP1375, nn SIF CA

SIF CAMP MIAMIN RD

State Registrar



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Amend: #24a Per MD Film G760 6-5-98RC Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** Girl 1998 Baby March 23:30 pm /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Baltimore City Bottomorg
If Under 24 Hrs. 8. Date
Hours Min. (Mo Medical Morcy enter MA If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Hours 3 Months Deys 1 M 2 F Usuel Residence of Decedent Yrs. Director USA the Meryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at Yes 2 No Director Baltimore City Raltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21218 Paul Street SA Funeral 210 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. Int: If item 27 is marked other than "naturel", or its 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0020 If Yes, Give Year or Detes: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) IÃ NIA NA 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Annleen Narold 20 Anthone Doreson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Doresa A. Thomas 2109 St. Paul street Baltimore, Maryland 21218 Saltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete Department of Important: If it any injury or o 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 ☐ Other (Specify) 21. Signeture of Fineral Serviced License ade, 3 Care and Affarolfy "Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 1 clas Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, a heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final · Cardiorspiratory 3 hs 53 mm diseese or condition resulting in deeth) Examiner Examiner one prematurate

Due to (or es e consequence of): Extreme sician and buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last physician a P.O. Box 68760. The law requires that the death certificate be Physician/Medical Due to (or es e consequence of): 88 950 ò signed by the el 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Aq 24b. Were autopsy findings aveileble prior to completion of cause of death? page 2 should Completed 24a. Wes en eutopsy peen 1 Yes 2 XX 1 □ Yes 2 □ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical Be 26. Piace of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 12 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homloide 1월 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier edical 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number P09708 workpero 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) - Univ. of MD Hed System, Pm NSW56, 22 S. Greene St. Baltimor HD 21201 R. Wohlberg 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State Registrar JUN 05 1998



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Tennev Bessie Kathern MAY 27, 1998 8:40 AM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthdey) Birthpiace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours 214-09-1108 Yrs. 96 1902 Director Maryland Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Maryland Washington Hagerstown X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1000 Hamilton Blvd. 21742 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: or items Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White P 3 NWidowed 4 □ Divorcad natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental is marked Edward Kennedy Mary Margaret Gibbs 2 of Health and M 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Hamilton Blvd., Hagerstown, Maryland 21742 Randal G. Hutson 20b. Piaca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Department of Himportant: If the any Injury or ot once. 1 XBurial 2 Cremetion 3 Removal from State Rose Hill Cemetery 5/30/98 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740

Approximate

Street

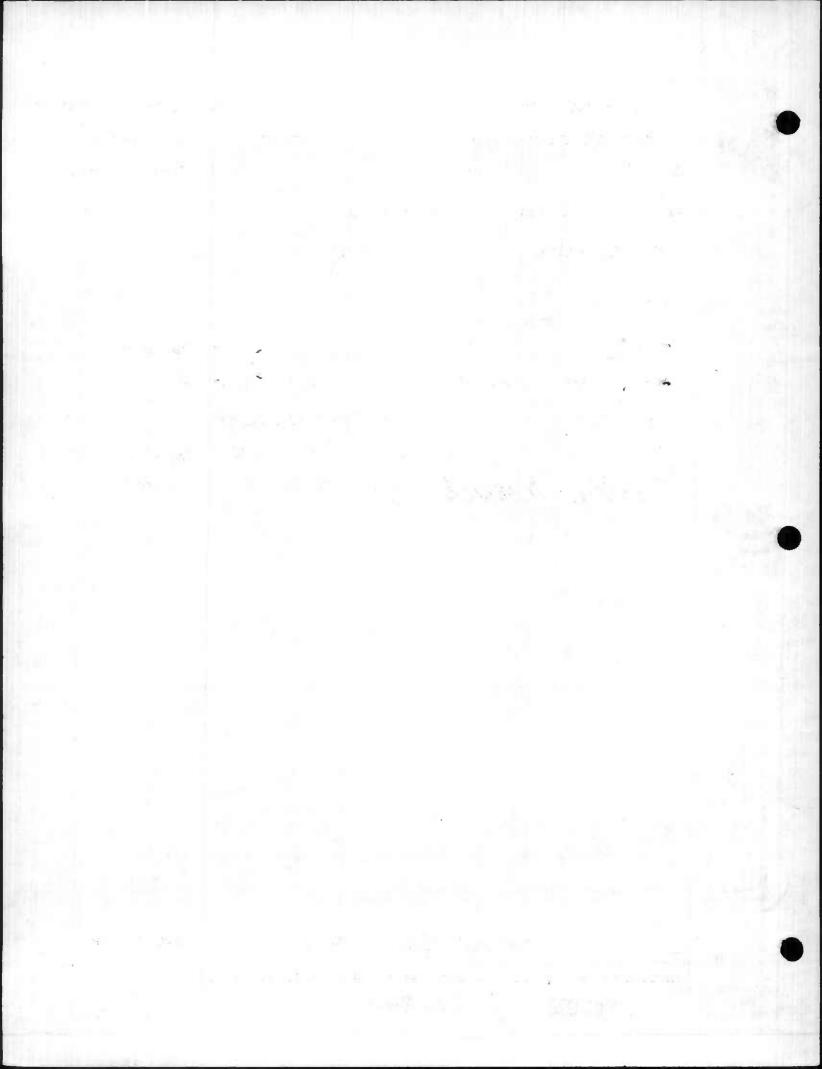
Funeral Home Hagerstown, Maryland 21740

Approximate Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final CONGESTIVE HEART FAILURE disease or condition resulting in deeth) **Examiner** 2 WEEKS Due to (or as e consequenca of) Examine MYOCARDIOPATHY MANY YEARS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. HYPERTENSIVE CARDIOVASCULAR DISEASE requires that the death certificate be MANY YEARS Physician/Medical Due to (or as a consequence of) 100 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DORSAL KYPHOSIS, CHRONIC OBSTRUCTIVE Records, à 24b. Were sutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? PULMONARY DISEASE WIE PBS PBS **DRG6 2** SONO certificate Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA ō # 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred sion Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D07857 MAY 28, 1998 30. Name end address of person who completed cause of death (ben 23a) (Type, Print) EDSON MOODY M.D., 1190 MT. AETNA ROAD, HAGERSTOWN, MD 21740 32. Redistrer's Signature 31. Date filed (Month, Day, Year) State JUN 0 5 1998 Registrar

TENNEY

KATHERINE

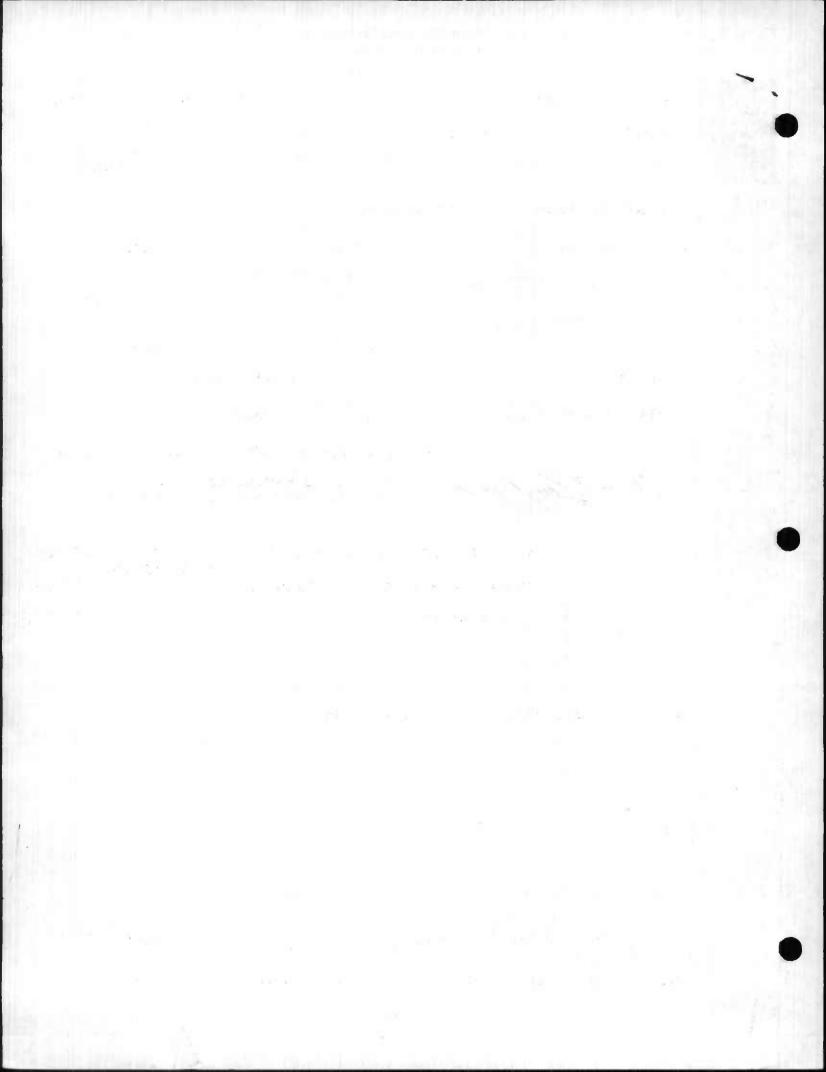


State of Maryland / Department of Health and Mental Hygiene D

Certificate of Death 1. Decedent's Name /First Middle Last) 2. Date of Death 3. Time of Death **Physician** Sarah R. 5 Day 1998 Per Turner JUY 1:56 AM /Medical 4e. Facility Name (If not institution, give street and number)
Franklin Woods Nursing Center 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Rossville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (State or Foreign VFromhia 5. Social Security Number 229-22-1100 If Under 24 Hrs. Hours Min. 8. Dete of Birth Notonth, Dan Years 18 **Funeral** 1 □ M 2 🔀 F Vra. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location Middle River 10a State 10b. Count 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, tra Medical Exaction resist be notified at Maryland Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 422 Wampler Road 21220 U.S.A. death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status Pages 1 end 2 should be filed within 72 hours efter or nent of Health and Mental Hygiene. Int: if tem 27 Is marked other than "natural", or iten Iny or other traumatic event, me Medical Exercises. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housewife Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Smith Pearl Robbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gerald W. Turner, Sr. (SON) 209 Homberg Avenue Baltimore, Md. 21221 altimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State permit. Page Department of Important: If any injury or once. Holly Hill Mem. Gardens 6/8/1998 Baltimore Co., Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Fecility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical immediate Ceuse (Finel ACUTE CEREBROVASCULAR ACCIDENT WITH LEFT disease or condition resulting in deeth) 10 Days Examiner Due to (or as a consequence of): HEMIPARESIS Examiner Arteriosclerotic Heart Disease 10 YRS. law requires that the death certificate be axecuted physician end the burief-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of) Hypertension 10 YRS. Box 68760, Physician/Medical the Due to (or as a consequence of): use as for use as ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Pulmonary Disease Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? pege 2 cartificata 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was cese referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this eral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28h Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? ther 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital of A 24 hours after Furferal Direct 29a. Certifier 🛍 Cartifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end manner es steted. 2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) June 5, 1998 D17728 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 8022 Belair Rd. Ba Yin Oung, M.D. 21236 Balto., MD State a Davidson

DHMH 16 Ray 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Deeth Dey **Physician** JOHN A. VOGET MAY 29, 1998 7:30 AM · /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** ANNE ARUNDEL GENERAL HOSPITAL ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 18 M 2□ F Months Deys Hours Yrs. Director 505-05-9442 98 SEP 8 1899 NEBRASKA Usuel Residence of Decedent the Manyland 10c. City, Town or Location 10a Stete 10h. County 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exameter must be notilled at 1 Yas 2 No Director POTTAWATTAMIE COUNCIL BLUFFS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 BENSON STREET 51503 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, ma Modif Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 25 No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 □ Naver Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) BUTCHER ARMOUR & COMPANY 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be JOSEPH W. VOGEL MARY ANN THOMPSON 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 674 DISCOVERY COURT, DAVIDSONVILLE, MD 21035 GEORGE VOGEL/GRANDSON 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, Steta 20e. Method of Disposition Burlal 2 Cramation 3 Ramoval from State HILLCREST 6/8/98 OMAHA, NEBRASKA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Sarvice Licenses 22. Name end Address of Fecility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVENUE, BALTIMORE, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final 2 weeks disease or condition resulting in deeth) neumoma Examiner Due to (or es e consequence of) Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) Plan ph Box 68760 Physician/Medical Due to (or as a consequence of) esn nse Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown muer live Division of Vital Records, by 8 24b. Were autopsy findings evellable prior to 24a. Wes an eutopsy performed? Completed completion of cause of death? has 2 No 1 Yes 1 ☐ Yas 2 ☐ No certificate Attanding Physician: funeral director, 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Naturel 5 Pending 1 TYas 2 No death. 2 Accident Investigation or Attancation after death 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homiclde Hospital 24 hours a 24 hours 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within 2 29b. Signatura end title of profiler 29c. Licensa number 29d. Dete signed (Month, Dey, Year) 38958 MD

Hungholy

Road #106, odenton MD 21113

State Registrar l. ei

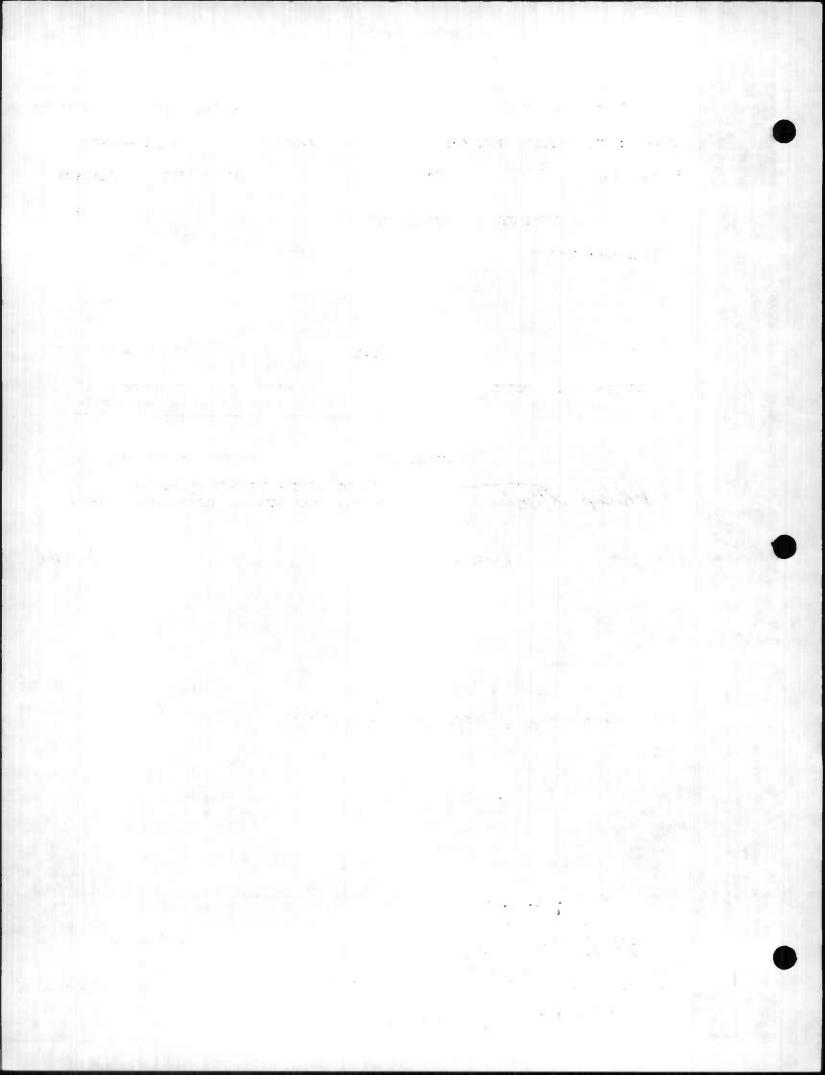
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth May 31, **Physician** 11:00 P.M. Alice E. Vanik /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not Institution, giva straet and number) Examiner Parkville Baltimore County Loch Raven Center If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Min 1 □ M 2 X F Months Hours 218-10-9279 Jan. 23, 1916 Maryland Director 82 Usual Residence of Decedent the Meryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County th and Mentel Hygiene.
7 is marked other than "natural", or frems 23s or 28s-f show traumstic event, or Medical Examinat must be notified as 1X Yas 2 No Baltimore City Maryland N/A Directo 10e Street and Number 10f Zin Code 10g. Citizen of What Country? with 21206 U.S.A. 4300 Glenmore Avenue Funeral filed within 72 hours after death 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarlo Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U.S. 11 Marital Status Bieck. White, etc. Armed Forces 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: p 3 Widowed 4 ☐ Divorcad White Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grede complated) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry mentery/Secondary (0-12) College (1-4or 5+) Theatre 10th Grade Manager 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be f nent of Health end Mentel I nt: if Itam 27 is marked of Messick William Edwin Floyd Lula Margaret 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Patricia Alice Freeland/Daughter 4300 Glenmore Avenue, Baltimore, Maryland 21206 : If Itam 27 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20e. Mathod of Disposition Dete 20c. Location - City or Town, State 1 XBuriel 2 Cremetion 3 Removel from Stete permit. Pege Depertment of Important: If any Injury or pace. Gardens of Faith Cemetery 6/3/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Fecility

John C. Miller, Inc. 21. Signature of Funeral Service Licenses ianuta 6415 Belair Road, Baltimore, Maryland 21206 thomas 23e. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, show or heert failure. List only one cause on each line. Approximete Interval Between Onsal and Deeth **Physician** /Medical Immediate Ceuse (Finel neuman disaese or condition resulting in deeth) Examiner Examiner ciation Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in deeth) Lesl Duly ar accident 20 covascu Physician/Medical Due to (or as a consequence of): P.O. Box 687 signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causs of death? Yss 2 No 3 Probably 4 Unknown þ Records, 24b. Were eutopsy findings availeble prior to completion of cause of death? 24e. Wes en autoosy Completed performed? WE certificate hes b lirector, page 2 s The 2 No 1 ☐ Yas 2 ☐ No 1 ☐ Yes Division of Vital director, Attending Physician: Be 25. Wes case referred to medical exeminer? 28. Piece of Daeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 Certification: To No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Maprier of Deeth 28b. Time of 28c. Injury at/ Work? 28d. Describe how Injury occurred 5 Pending investigetion Neturei 2 Accident 1 Yes 2 No Director: A 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 6 To the Hospital or within 24 hours aft To the Funeral DI completely filled in edicai 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner stated. 29e. Certifier

State

Registrar

cis 31. Date filed (Month, Dey, Year) JUN 0 5 1998

29b. Signeture and title of certifier

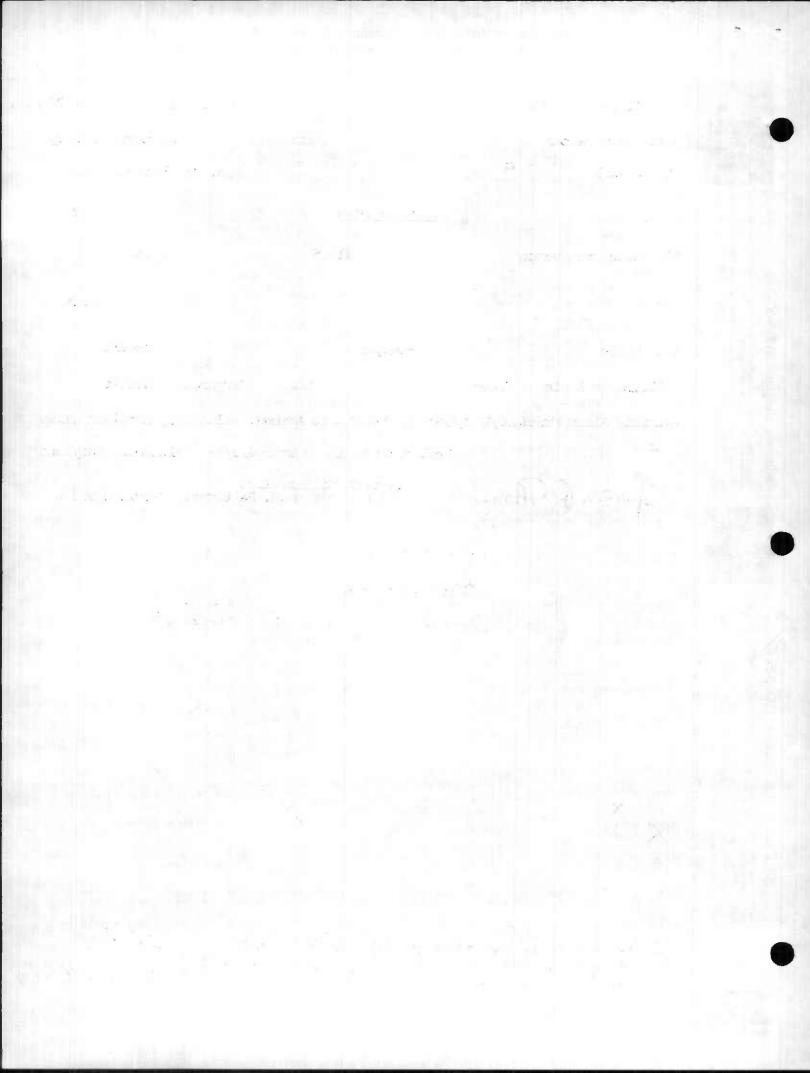
a 32. Registrar's Signature Wondard

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(Type, Print)

29c. Licanse number

29d. Date signed./Month. Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Deeth MAY **Physician** 29 Day WHITE 1998 OSE 18:18 MAE /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY NA If Under 1 Year Date of Birth (Month, Day, Year) 08-12-32 Birthplece (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Hours Min 1 M 2 D.F 218-26-2942 65 Yrs Director Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "natural", or items 23a or 28a-f show other traumstic avent, the Medical Examinal must be notified at Y Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 207 St. 21202 Matthews Street USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Meritel Status should be filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2KDXNo Specify: Specify: à 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Hostess Maryland Club 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, h and Mental h Thomas Joseph Rose Mae Johnson 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 permit. Pages 1 end 2 Department of Health a Important: If item 27 le Pritchett 207 St. Matthews Street Baltimore, Md. Catherine 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Suriel 2 □ Cremation 3 □ Removel from State ò 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 06-06-98 Dundalk, Md. any Injury 22. Name end Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue emand moun 23a. Part1. Enter the disease, or confdications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** tmmediate Cause (Finel diseese or condition resulting in deeth) /Medical BACTERIAL **Examiner** Examiner requires that the death certificate be axecuted ettanding physician end for use es the bunal-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760. FAILURE Physician/Medicai Due to (or as e consequence of): 80 MELLITUC Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown igned by Division of Vital Records, Àq 8 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed certificata has 2 12 No 1 ☐ Yes 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 1 PNatural 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? or Attending 5 Pending investigation after death. 1 TYes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medicai 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) onel within 2 To the 29c. Licens number 29b. Signatu 29d. Dete signed (Month, Day, Year)

State Registrar 30. Name and

31. Dete is and (Month, Dey, Year)

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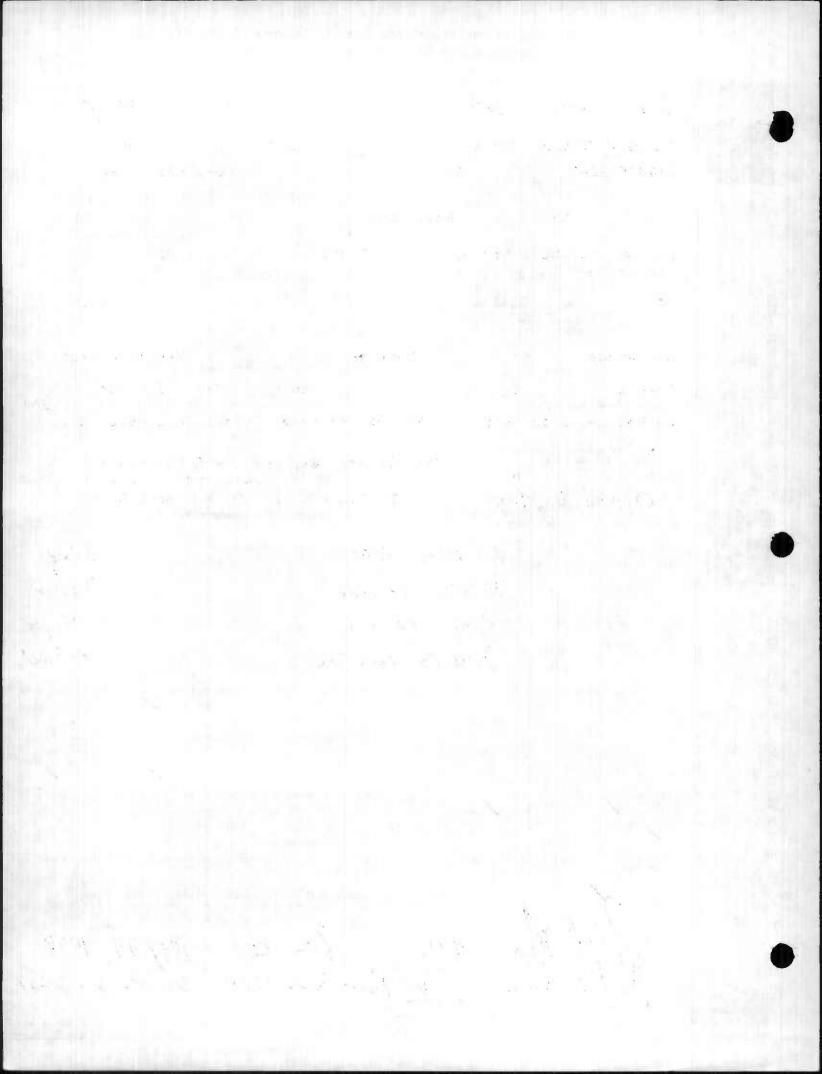
of person who completed ceuse of deeth (Item 23e) (Type, Print)

32. Regim

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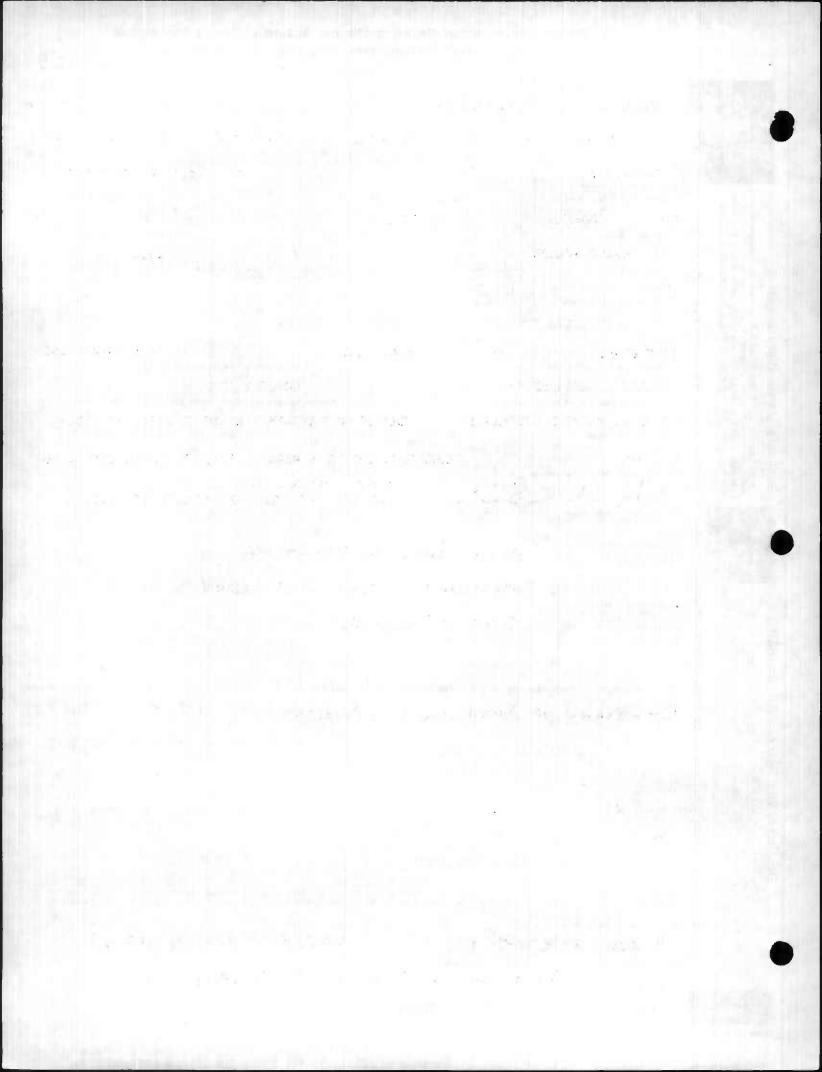


State of Maryland / Department of Health and Mental Hygiene

				Certi	ificate c	of Death		Reg. No.)	1459		
Di	1. Decedent's Name (First, Middle, Las									3. Time of Deeth		
Physician /Medical	VIRGINIA L.	INIA L. WILHELM							Yeer 98	6:40 PM		
Examiner	4e Facility Neme (If not Institution, give	1				4b. City, Town, or						
	SHOCK TRAUMA	VUNIV C	E WY	AJ YS	ND	BALTIN	ORE	BAU	DOMIT	SE CITY		
Funeral Director	5. Social Security Number 6. Security Number 218–42–7847 Usuel Residence of Decedent	THE OFF	e (In yrs. lest b		If Under 1 Ye Montha De			th ly. Year) 8,1944	9. Birthple Countr MARYI	ece (Stete or Foreign y) AND		
show	10e. Stete 10b. County		10c. City, To	wn or Loca	tion				10	d. Inside City Limits		
to to	MD HOWARD		ELLI	COTT	CITY					1 ☐ Yes 2 ☒ No		
or 28a-f s be notified Director	10e. Sfreet end Number				10f. Zip Cod	ie	T	10g. Citizen of	Whet Countr	ry?		
0 E 0	9389 FURROW AVENU	Е				21042		U.S.	Δ.			
edical Examiner must be notified at letted by Funeral Director	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 251 If Yes, Give Yeer or Dates:			es Decedent of es, specify C	of Hispenic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yea or No o Rican, etc.)		ce - America ck, White, e	tc.		
le le	15. Decedent's Ed		166	e. Decader	nt's Usuei Oc	cupetion		16b. Kind of B	usiness/indu	ustry		
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matic event, tra.M. To Be Comp	12TH GRADE	0		SECRETARY				FEDERA		RNMENT		
Se ve	17. Fether's Name (First, Middle, Last)					18. Mother's Ner	ne (First, Middle,	, Meiden Sumer	ne)			
5 P	CHARLES G. HUBBAR	D,SR				DOROTH	IY KEMP					
En	19e. Informent's Neme/Relationship (T	ype, Print)	19	b. Mailing	Address (Str	reet end Number or Ru	ıral Route Numb	er, City or Town	, Stete, Zip (Code)		
b	HARRY W. WILHELM	(HUSBAND)				W AVENUE -	ELLICO	TT CITY	, MD 2	1042		
or other traumatic event, Ira.M. To Be Comp	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremefion 3 ☐ I	Bamayai from State	20b. Piece cemet	of Dispositery, creme	ion (Neme of tory or other	f plece)	Dete	20c. Location	- City or Tow	m, State		
o ću	4 Donatton 5 Other (Specify		CREST	LAWN	MEMOR	IAL PARK	6/1/98	MARRIO'	TTSVII	LE, MD		
eny Injury	21. Si nature of Funerel Service Licans											
eny injury or othe	HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between interval Between											
Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lesf	META	Due to (or es a	conseque conseque CAN	ence of): CER CER	MASS L						
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by Physician/	Pert II. Other significant conditions co							tobacco usa co Yes 2 No	3 Prob	the causs of death?		
pleted							24e. Wes	en eutopsy ormed?	com	re eutopsy findings ilebie prior to apletion of cause eeth?		
rector, page 2 Be Comp							10	Yes 2000	10	Yes 2 No		
Be Be	25. Wes case referred to medical examiner?	14					eth (Check only	one)				
2	1 ☐ Yes 2 No	Hospital: 1 npatie	ent 2 ER/C	outpatienf	3□ DOA	Other: 4 Nursing h	lome 5□Resi	dence 6 Ott	ner (Specify,)		
completely filled in by the funeral director, Medical Certification: To Be (27. Menner of Death 1 Selection of Legal Place of Injury 2 Accident investigation 3 Suicide 6 Could not be							how injury occur				
Medical Certification	4 Homicide determined	28e. Plece of Inj building, et	ury - At home, t c. <i>(Specify)</i>	erm, stree	t, rectory, offi	ica	28f. Location (City or To	Street and Numi wn, Stete)	oer of Hufa!	noute Number,		
pletely filled edical C	29a. Certifier 1⊠ Cartifying Phy cone) 1 Cartifying Phy 2 Medical Exami	sicien: To the best iner: On the besis of end menner sta	examinetion e	ge, deeth o nd/or inve	eccurred at the stigetion, in m	e time, dete end plece ny opinion, deeth occu	, end due to the urred et the time,	cause(s) and m dete end pieca,	enner es ste end due to	ited. the cause(s)		
w com	29b. Signature and title of certifier **Euror** B. X	reall. E	90			ense number 3/298		29d. Dete signe	2 -9 6	ley, Year)		
State	30. Name and address of person who con KEVIN B. GE. 31. Date filed (Month, Dey, Year)	ROLD, DO	leeth (Item 23e) 22 er's Signeture	S. G.	int) REENE	31298 EST, BA	LTMUSRE	E, MD	212	201		

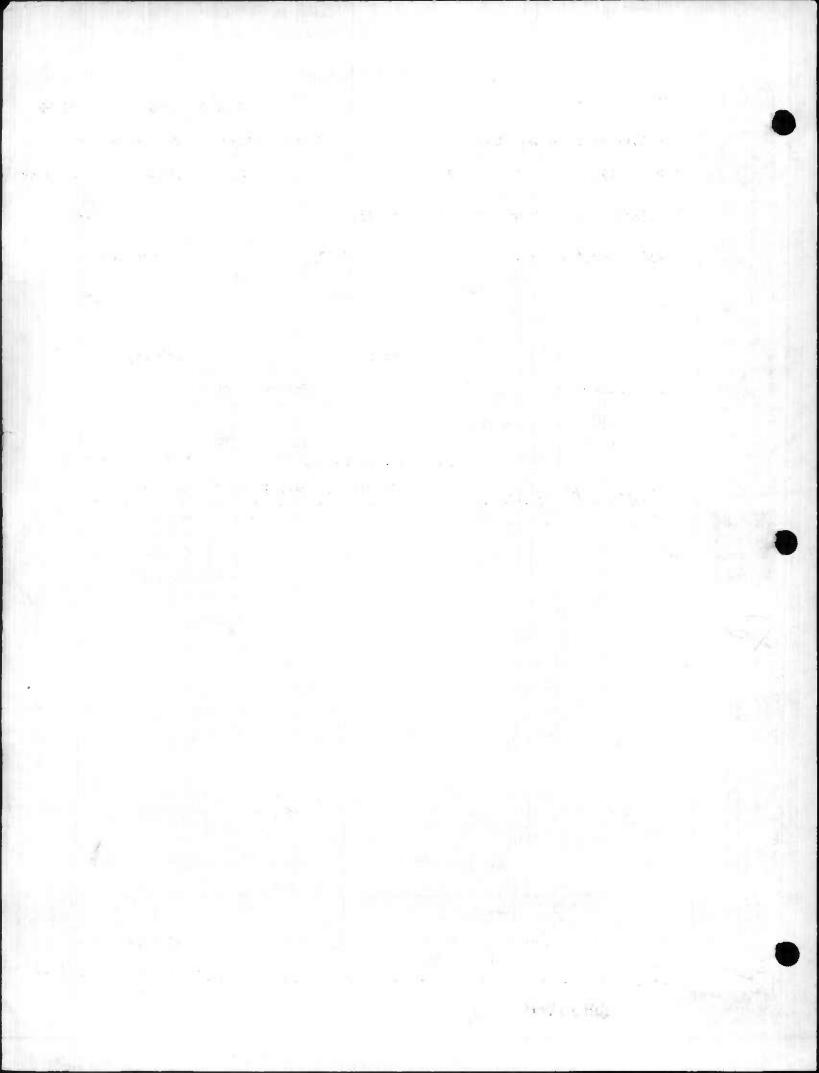
State Registrar

JUN 0 5 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_				Certifica	ate of	Death		Reg. No.	8	7460
Physicia /Medic		1. Decedent's Name (First, Middle, Las Jane L. Zack	•					2. Date of D Month June 2	Day 1998	Year	3. Time of Dea 8:45 PM
Examin	ier	4a. Facility Name (If not institution, give					4b. City, Town, or Lo			unty of Deat	
		Collington Life					Mitchellv:				orge's
Funeral Director		5. Social Security Number 280 30 4022 Usual Rasidence of Decedent	7. Age	(In yrs. last birth	Month	der 1 Yaar ns Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Nov. 1	rth ay, Year) 6,1915	9. Bin Co Ma	hplace (State or Fo nuntry) ssachuset
show		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Li
death with the Maryland rms 23a or 28a-f show	to	Maryland Prince	George's	Mitch	el l víl	1e					XIN Yes 2
or 28;	rec	10e. Street and Number			10f. 2	Zip Code			10g. Citizen	of What Co	untry?
23a o	a D	10450 Lottsford	Road			2072	21	Unit	ed St	ates	
or its	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 253 No If Yes, Give Year or Dates:			cedent of Pecify Cub	Hispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yes or N Ricen, atc.)	No- 14. Race - American India Black, White, etc. Specify: White		ericen Indian, e, etc.
natural',	ted ed	15. Decedent's Edu	ucation	16a. [Decedent's U	sual Occup	pation	to a	16b. Kind	of Business/	Industry
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s should be fried within and Mental Hygiene. Is marked other than aumatic event, the Mental Hygiene.	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle	a, Maiden Sui	mama)	
marked o	2	James Nesworthy					Gertrude	e Young			
and is m		19a. Informant's Name/Relationship (T)	ype, Print)	19b.	Mailing Addre	ess (Street	end Number or Run	a <i>l Rou</i> te Numi	per, City or To	wn, Stete, 2	Zip Code)
f Health and Meritem 27 is marke other traumatic		Linda Tarr-Whelan	Daughter				Lane Arl:		Virgin	ia 2	2207
Department of He Important: If item any Injury or othe pace.		20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ F	Computed from State	20b. Placa of I cemetery	Disposition (A , crematory o	leme of r other pla	ca) June 4,	1998	20c. Locati	on - City or	Town, State
Department of Important: If its any injury or of once.		4 Donation 5 Other (Specify)	temovar nom otate	The Hu	ntt Cr	emat	ory		Waldo	rf Ma	ryland
hysician /Medical		23a Party Enter the disease, or companies, or heart failura. List conditions transduced the conditions of the conditions			16000 ot enter the m	Ann		. Bowie	Marv1		0715 Approximate Interval Betwee Onset and Deat
xaminer		disaasa or condition resulting in deeth)	. Se Chole	-poco							74 Km
100	ē			Due to (or as a co	ensequence o	of):					weeks
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igned by the attendit	by Physician/	Dementia						10	Yes 201	lo 3 P	robably 4 🗆 Unk
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ertific	00	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only	one)		
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r death. ector: Affer this certific by the funeral director,	Certification:	27. Menner of Death 1 Natural 5 Pending 2 Accident Invastigation	28a. Dete of Injury (Month, Day	Year) 28b. Tir	ne of ury M	28c. Injui Woi 1 🗆	y et rk? Yes 2 □ No	28d. Describe	how Injury or	curred	
is after led in the le		3 Suicide 6 Could not be determined	n, streat, facto			City or To	wn, State)		iral Route Number,		
in 24 hou he Funet pletely fil	edical	29a. Certifier 1 Certifytng Physical Check only one) 1 Medical Examination	sician: To the best of ner: On tha basis of e and manner state	examination and/	death occurre or investigation	ed at the tir	me, date and placa, pinion, death occurr	and due to the ed at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
Tot	Eller I	29b. Signatura and title of certifier	1	- 6-		9c. Licans					h, Day, Year)
V		Dull de Y	- / 1	PO (3)		125	-57 g		4/31	18	
		30. Nama and address of person who co	1	ath (Item 23a) (T	ype, Print)	uti	ve place	# 0-0	¿ Jen	troop	mo 707
		On the London		1 1 0 0			7		,	6	diam'r L

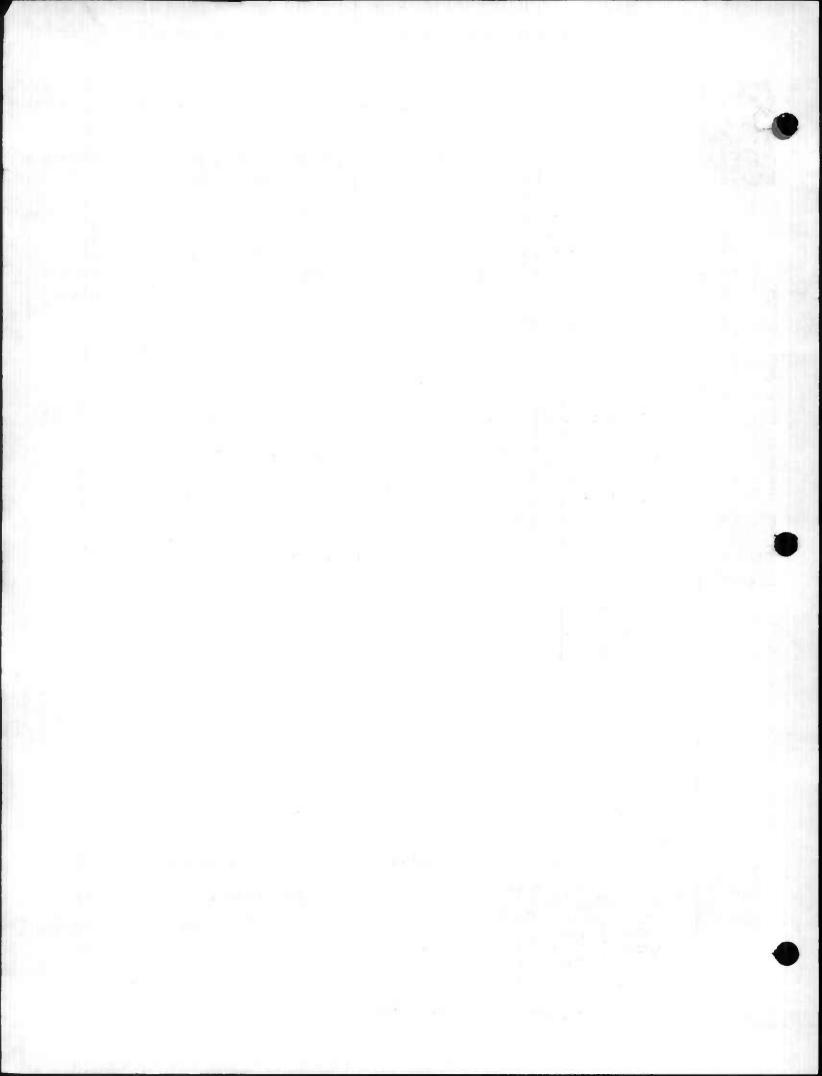


State of Maryland / Department of Health and Mental Hygiene Q

					Certificate of	f Death	F	Reg. No.	- 1	7401
Physic		Decedant's Nama (First, Middia, Last	Virgil	Lee	Andrew		2. Date of Dec		8 ^{Yaar}	3. Tima of Death 3:00 Al
/Med Exami		4a. Fecility Nama (If not institution, give Shore Nursing	street end number)			4b. City, Town, or Lo		4c. County		
Funeral Director		5. Social Security Number 217-30-7599 6. Sa	7. Aga (In	yrs. last bir 85	thday) If Undar 1 Yea Months Day		8. Date of Birth (Month, Day 09/1/	h v. Year) / 1 2	9. Births Cour Mar	plece (Stata or Foreigntry)
Maryland a-f show	tor	Usuel Residence of Dacedant 10a. Stata 10b. County MD Caroli		c. City, Tow	n or Location Fe	deralsbu	rg		1	10d. Insida City Limit
h with the 23a or 28	Funeral Director	10e. Street and Number 4828 Preston Ro	ad		10f. Zip Coda	21632		10g. Chizan of V United		
Ind 21215-0020 be filed within 72 hours efter death with the Maryland tel Hygiene. d other than "natural", or items 23a or 28a-f show event, tre Madical Exercises must be notified at	by	11. Marital Status 1 Nevar Marriad 2 Merriad 3 Widowed 4 Divorced	12. Wes Dacedant Evar Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give Yaar or Datas:	in U,S.	13. Was Decedant of If Yes, specify Cu	Hispenic Origin? (Sp iben, Maxican, Puarto o Specify:	ecify Yas or No- Ricen, etc.)	14. Race Blace Specify	k, Whita,	can Indian, etc. Vhite
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours of begaring of Health end Mentel hygiene. If them 27 is marked other than "natural", or my nightly or other traumetic event, the Medical Examples.	Be Completed	15. Decedant's Edu (Spacify only highast grad Elamantary/Secondery (0-12)	cation a com <i>plated)</i> Collage (1-4or 5+)	16a.	Decedant's Usual Occi (Giva kind of work don lifa. DO NOT use retin Farmer	upetion a during most of work red)	working 16b. Kind of Business/Industry Agriculture			
Maryland 2121 12 should be filed within h end Mentel Hygiene. 7 is marked other than "	To Be C	17. Fathar's Nama (First, Middia, Last)	lbert T.	Andre	ew	18. Mothar's Name Minnie			Θ)	
re, Maryld s 1 and 2 should f Health end Mer tem 27 is marke other traumatic		19a. Informent's Name/Relationship (Ty Richard L. And	rew/Son	19b	Mailing Addrass (Street 4822 Pres	et and Number or Run ton Rd.,	Feder	ar, City or Town, alsbur	Stata, Ziç G, N	Code) 1D 21632
Baltimore, Mapper permit. Pages 1 and 2. Department of Health en Important: If Item 27 is any injury or other trainons.		20a. Mathod of Disposition 1	lamousl from State	cemeta	Disposition (Nama of ry, cramatory or other pi Crest Ce	metery	Data 5 / 28	20c. Location - Feder		
Demit. Department. Importa		21. Signatura of Funaral Sarvice License	isker		22. Nama and Add Framptom PO Box 4	rass of Fecility -Hawkins 3, Feder	-Eskow alsbur	Funer	al H 2163	Home, PA
Physician /Medical Examiner	iner	23a. Part1. Entar tha diseesa, or complishock, or heert failura. List only or Immediata Causa (Final disease or condition resulting in death)	A	pn	eum o i					Approximeta Interval Batween Onsat end Death
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IS, P.O. BO) so that the death ce igned by the attendi	by Physician	Part II. Other significent conditions cor	ntributing to death but not	4		givan In Part I.	23b. Did t			o the cause of death
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State Registrar

32. Registrar's Signatura 31. Date filed (Month, Day, Year) MAY 2 6 1998



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	13. Was Decedent of I If Yes, specify Cub I Yes, specify Cub 1 Yes 2 10 No Decedent's Usual Occurrence of I Yes 2 10 No Decedent's Usual Occurrence of I Yes 2 10 No NoT use retires OUSEWIFE Melling Address (Street 45 Lockwood) Seposition (Neme of creme for year of the Policy of the Policy of the Policy of the Policy of the Policy of the I Yes 10 No Not year of Yes 10 No No No No No No No No No No No No No	Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired) OUSEWIFE 18. Mother's Name Elizabet Melling Address (Street end Number or Run 45. Lockwood Drive, if Disposition (Neme of cremetory or other piece) Lincoln Cemetery 22. Name end Address of Facility Gasch's Funeral Hory 4739 Baltimore Aver in enter the mode of dying, such as cardiact insequenca of): Shock Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: Shock Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: Shock Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho Insequenca of Deat Other: And Nursing Ho I	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Decedent's Usual Occupation Give kind of work done duning most of working file. DO NOT use retired) OUSEWIFE 18. Mother's Name (First, Middle, Elizabeth Verm: Welling Address (Street end Number or Rural Route Number or remetory or other piece) Lincoln Cemetery 5/22/98 22. Name end Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hya Henter the mode of dying, such as cardiac or respiretory end Henter the mode of dying, such as cardiac or respiretory end SACK Insequenca of): SACK Insequenca of): Calculate A Was perform 24a. Was perform 25. Placa of Death (Check only of the control of the contro	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1	13. Was Decedent of Hispanic Origin? (Specify Yes or No-Wes, specify Cuben, Mexican, Puerto Rican, etc.) 1					

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) vashinglon Havenis Ma 24 Hrs. lon Ta Tark 7. Aga (In yrs. last birthday) 9. Birthplace (Stata of Foreign Country) 6. Sax Days Min 1 M 2 KF Va Usuel Residence of Decedani 10a. State 10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country? Rhue 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yes or If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Marriad 2 Married 1□Yes 21 No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry ndery (0-12) College (1-4or 5+) Grade 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Nema (First, Middla, Last) 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number YUTTS VILL Md 20783 20c, Location - City or Yown, State Son 20a. Method of Disposition Data 05-23-48 Burial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funerel Service Licensee 23a. Part1. Enter tha disease, or complications that caused tha death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arre CE REBRAL VASCULAR ACCIDENT Immediate Cause (Final disease or condition resulting in deeth) EMIC HYPERTENSION Due to (or as a consequence ot): STEMIC CEREBRALVASCULAR ACCIDENT Dua to (or as a consaquanca of): ERLIPIDEMIA Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to complation of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

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Baltimore, Maryland 21215-0020

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Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events

resulting in death) Last

2 XN0 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 tnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, streel, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

12 Cartifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. ninetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

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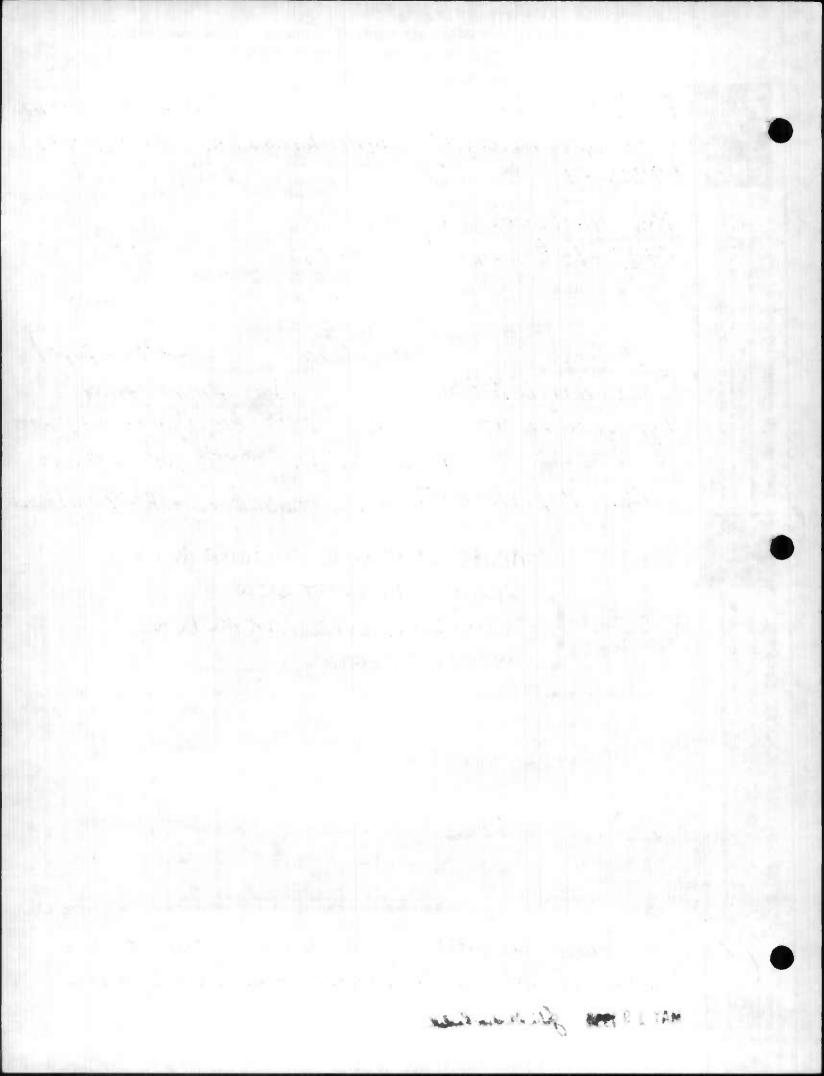
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

3415 HAMILTONST. HYASVILLE, MD 20782 STEVEN TEE MD

State Registra

31. Date filed (Month, Day, Year) 32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Glen L. Breedlove May 6:21 AM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Harford Memorial Hospital Havre de Grace Harford If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Ye 6. Sex 1 ⋈ M 2 ☐ F 5. Social Security Number 9. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Vrs 223-10-6746 80 Virginia 6, Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maruland Cecil Conowingo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 857 Ragan Rd. 21918 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Coal Miner Coal Mines 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Roy Breedlove Rosie Due 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lona M. Breedlove/Wife 857 Ragan Rd. Conowingo, MD 21918 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) West Nottingham Cemetery 5/28/98 Colora, Maryland R. T. Foard Funeral Home, P. A. 111 S. Queen St. Rising Sun, MD 21911 21. Signeture of Funeral Service Licensee inler the disease, or complications that he heert feilure. List only one ceuse eth. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) 1 WIC 1 WIC Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest arl ONLAN 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Valentar delicas 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

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Box 68760.

P.O.

Division of Vital Records,

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Physician/Medical Examiner

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28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

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28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Waturet

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier

MD

29c. License number

29d. Date signed (Month, Day, Year)

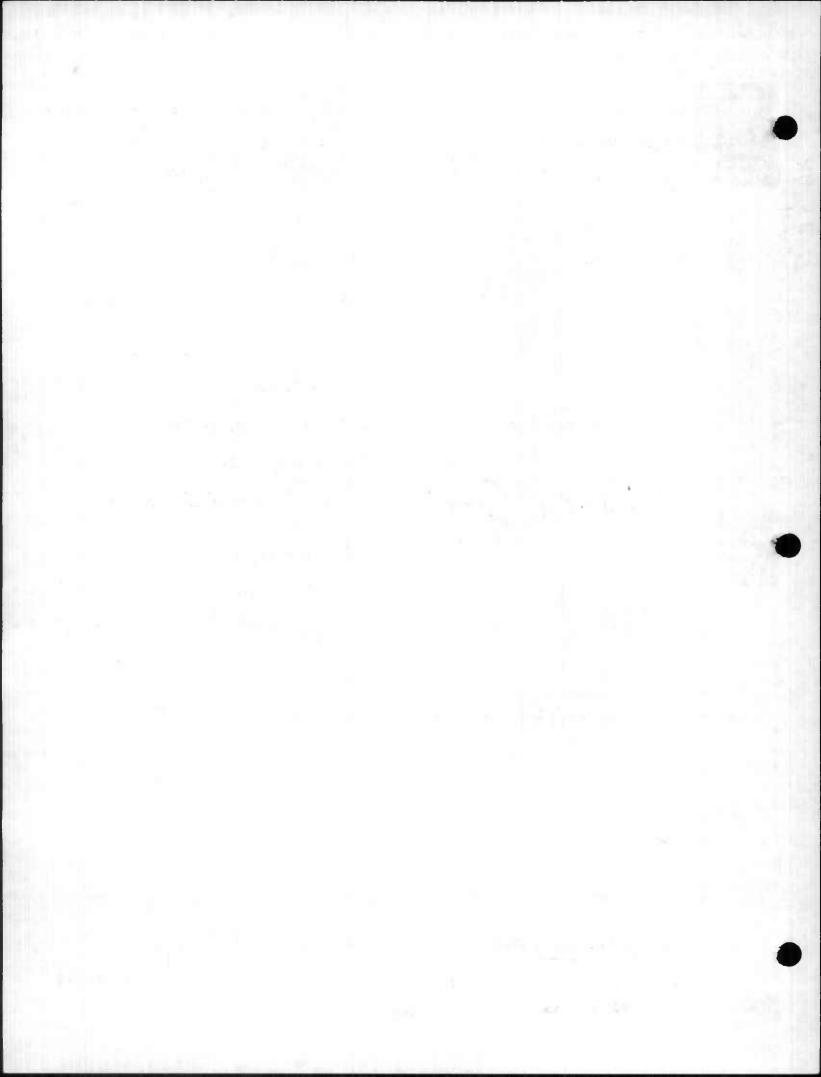
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30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Kammelin Miham' no 703 Revolution St - Harr Pc Grau no 21078. 32. Registrar's Signature

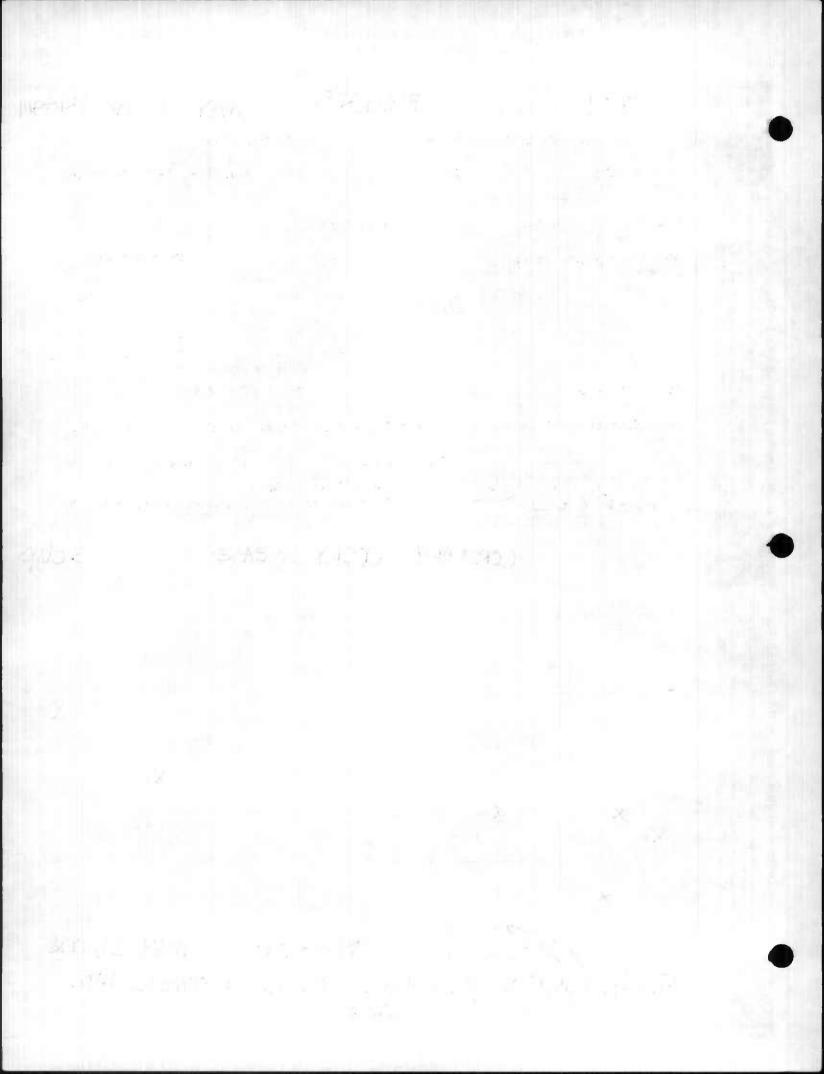
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completely filled in by the funeral	3	> /	11	ND. =	I death (Item 23)	a) (Type,	Print) R	tb	spita	100 al,	Balt	may	21 2, N	, 1998 D.



THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Deat of Health and Mental Honline prior to hurial remaining or remaining the month.	is marke
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA CERTIF	RTMENT (F HEALTH AND OF DEATH	MENTAL HYGIEN		J {	140	0		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3.	TIME OF DEAT	Гн		
	LLOYD EDSEL	BROWN		05/22/98 YEAR 10:4								
	4. SOCIAL SECURITY NUMBER	4 SOCIAL OFCHOUS HUMBER										
	219-05-3883	1 🕅 M 2 🗆 F 82	YRS.	MONTHS D	AYS HOURS MIN.	(Month, Day, Year) 02/11/1		Country)	ACE (State or Fo yland			
	9e. FACILITY NAME (If not institution, give s	treet end number)		9b. CITY, TO	WN OR LOCATION OF D		9c. COUNT					
DIRECTOR	Peninsula Regional Med. Center Salisbury, Maryland Wicomi											
H	10e. STATE 10b. COUNT		10	d. INSIDE CITY								
	Md. Word	ester	S	now H	ill			1	YES 2	NO		
A	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZE	N OF WHA	T COUNTRY?			
Ä	211 E. Federal				21863		U.	S.A	•			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	a or No — 14	RACE -	American India	en,		
ВУ	1 Never Married 2 Narried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			ns, specify Cuben, Mexic YES 2 1 NO Spec			Specify:		1		
	100000000000000000000000000000000000000								white			
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade	completed)	18e. DECEDENT'S (Give kind of life. Do NOT	work done durk	IPATION ng most of working	16b, KIND OF BU						
) E	Elementary/Secondary (0-12)	College (1-4 or 5 +)				Moore	Busi	nes	s For	ms		
ME	17. FATHER'S NAME (First, Middle, Last)		macmi	пе ор	erator	Print						
S	James Brown					AME (First, Middle, Maiden						
BE	19e. INFORMANT'S NAME (Type/Print)		-			cence Kid	-					
9		Wife				Route Number, City or Tow			03.06			
	Mabel L. Brown					.,Snow H				3		
	206. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Cematary, crematory or other place) Makemie Presbyterian 5/25 Snow Hill, Md.											
	4 Donalion 5 Other (Specify) 21. SIGNATUBE OF FUNERAL SERVICE LIC		akemie									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY P.O. BOX Dennis Funeral Home, Snow Hill											
	Tarricia.	L. Den	us	De	nnis rune	eral Home	, Sno	W H	111,MG 1863	a.		
CERTIFICATION	23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A	CONSEQUENCE C	Heart Cardiev		cow thold			Approximinations interval Bi Oneat and	atween		
	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
8		d										
PHYSICIAN: MEDICAL	1,05	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2X NO 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
5	DID TOBACCO USE CONTE	RIBUTE TO CAUSE O	F DEATH Y	ES NO	LINCERTAL	N D		'	YES 2 N	**		
¥.	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA					1				
Sic	EXAMINER? 1 Tes 2 X NO	HOSPITAL: 1 X Inpatient 2 ER/Outp	Home 5 🗆 Residence	a (7) on (0)								
Ħ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIR		. INJURY AT	28d, DESCRIBE HOW I	NURY OCCUR	RED		-		
	1 Netural 5 Pending	(Month, Day, Year)	IN.	JURY	WORK?			L		- 1		
ВУ	2 Accident Investigation 3 Suicide P Could get be	28e. PLACE OF INJURY	— Al home, ferm,			28f. LOCATION (Street	and Number or	Quest Bout	a Mumbar			
COMPLETED	4 Homicide B Could not be	building, etc. (Spec	ffy)			City or Town, State)	end wanter of	THORE THOO!	o reamber,			
۳	290. CERTIFIER	CIAN: To the best of my knowl	adaa daath aanu	and at the time								
N N	(Check only one) 2 MEDICAL EXAMINE	R: On the basis of examination	end/or investigation	on. In my opini	on, death occured at the	time data and place or	nner ee stated,	muncia) an	d manner on at			
	29b. SIGNATURE AND TITLE OF CERTIFIER		Carl McGara	9						ared.		
ᇤ	CO AGO A A I	00000	2		29c. LICENSE NU	MBER	29d. DATE S	IONED (Mo	onth, Day, Year)			
2	30. NAME AND APPAESS OF PERSON WHI	COMPLETED/CARSE OF DE	TH (ITEM 27) /3-	- Print)	1/01	76 4		5/20	6198			
	JAMES L. CAIFED	ROMA 10	6 PINE 1		Ro Suiral	2 Saus	anny	Mo	2/80	4		
2	MAY 2 7 1998 32. REGISTRAR'S SIGNATURE Sulfa Duilon Wines											

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** WARREN SYLVESTER BRILLHART May 24, 1998 7:10 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street and number) Examiner Berlin Worcester Atlantic General Hospital if Under 24 Hrs. If Under 1 Yeer Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Min 1 M 2□ F Months Dsys Hours Oct. 4,1923 74 Pennsylvania Director 196 18 5822 filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10e Stete r 28a-1 show 10b. County 10d. Inside City Limits 1 Yes 2 □ No Directo York York 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 17404 2145 High Street U.S.A. Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Order 2 No It Yes, Giva 1941 1945 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 5/24/98 0710 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Sales Tool & Die Co. 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Heelth and Mental Int: If Itam 27 is marked of Grace R. Stevens George M. Brillhart 19e. Informant's Name/Reletionship (Type, Print) son-in-19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morris T. Rutledge -Ocean City, MD 21842 Dete 20c. Location - City or Town, Stete 120 53rd St. Q 101 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) uriel 2 Cremation 3 Removel from State Shiloh Lutheran Cemetery 5/29/98 ork, PA 21. Signalate of June 1 Service Licenses 22. Name end Address of Fecility 108 William St. Burbage Funeral Home Berlin, MD 21811 that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, a on each line. Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediata Cause (Finel diseese or condition resulting in deeth) EVERAL YRS Examiner Examiner physician and the buriel-transit Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseesa or Injury that initieted events resulting in deeth) Last Dua to (or es e consequence of): the deeth certificate be execu Box 68760 Physician/Medical Due to (or es e consequence of) 88 esn 23b. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t d be detact 1 Yes 2 No 3 Probably 4 Unknown p Division of Vital Records, 24b. Wara eutopsy findings eveileble prior to completion of cause of daath? Brillhart Completed 24a. Was an autopsy performed? this certificate has 1 ☐ Yas 2 No 1 Yes 2 No Attending Physician: funeral director, 25. Was case referred to medical Be 26. Plece of Deeth (Check only ona) exeminer? To Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending Injury Netural 1 ☐ Yes 2 ☐ No investigation after deeth Director: A d in by the f 2 Accident 6 Could not be datermined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hou. the Funeral Directifiled in by 4 I Homicide 8 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to tha cause(s) end mannar as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred et the time, dete and place, and due to tha cause(s) end menner stated. 29e. Certifier Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) world 30. Neme end address of parson who complated 203 SNOW ST, SNOW HILL MD 63

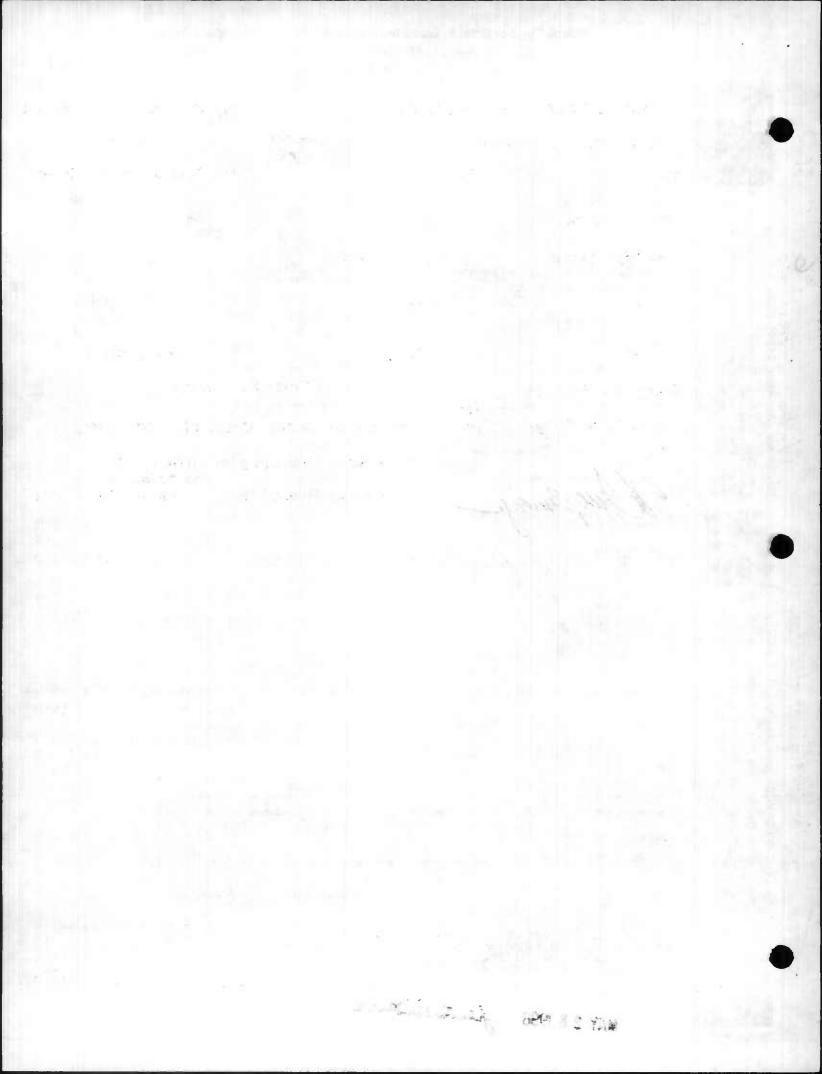
32. Ragistrer's Signeture

DHMH 16 Rev 6/95

State Registrar

31. Data tiled (Month, Day, Year)

Narren



State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** 25 Stanley C. Ballard May 1998 2:05 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Charles County Nursing Rehab Center LaPlata Charles 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 013-03-1312 Yrs. Director 86 911 MASS Aug. Usuei Residence of Decedent 10e. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Charles Waldorf **Funeral Director** 1 ☐ Yes 2 ☑ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? or items 23a or 4069 Green Spring St. 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. Yes 25No 1 ☐ Never Married 3 € Married 1□ Yes 25 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. ther than Elementery/Secondery (0-12) College (1-4or 5+) Industrial hygiene engineer Insurance 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Walter Clark Ballard Clara Bigelow Ballard amd is 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Important: If item 27 is any injury or other tra-once. Arline Spencer Ballard/Wife 4069 Green Spring St. Waldorf, MD 20601 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5/27/98 Alexandria, VA 21. Signature of Funerel Service Licensee 22. ARBHARE BECHOLS FUNERAL HOME, PA P.O. Box 567 LaPlata, MD 20646 M00945 23a. Part1. Enlier the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shook, or heert feilure. List only one ceuse on each line. Approximate Onset and Death **Physician** /Medical Immediete Ceuse (Finel TO 030 wid disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 5 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown by Completed 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No patient 2 ER/Outpetient 3 DOA 2 s efter death.

I Director: After this ed in by the funeral d 27. Menner of Deeth 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner steted. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed ceuse of deeth (Item 23a) (Type, Print) Walters Mis Junte 100 0/9 700 Canto

State Registrar

Registrar's Signature Year)

Maryland 21215-0020

Pages 1 and 2 should

The law requires that the death cartificate be executed

certificate

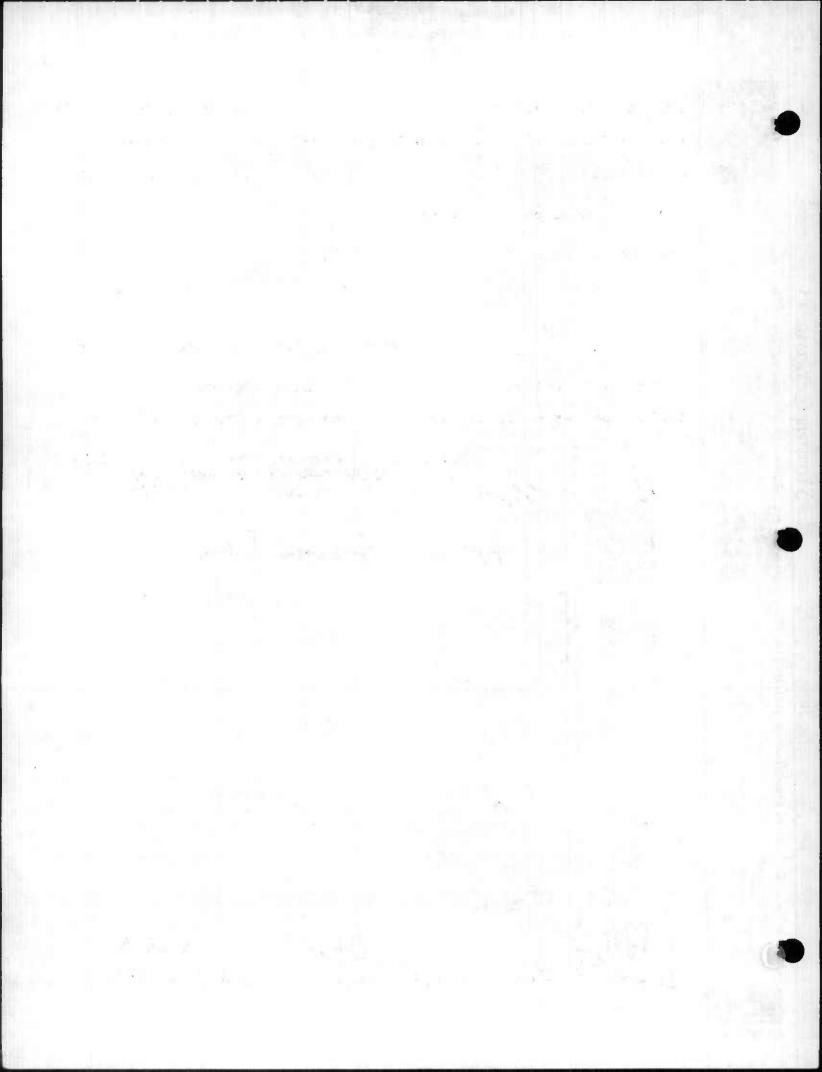
this

or Attending Physician:

Division of Vital Records, P.O. Box 68760.

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tanley C. Ballard



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Data of Deeth 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Day Month 05 21 98 11:25a.m JOHN ROBERT BRITTON 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nama (If not Institution, give street and number) Ft. Washinton
ff Undar 1 Year | If Undar 24 Hrs. | 8. Data of 8 8106 Comet Dr. 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Yaar) Months Deys Hours Min. 10 M 20 F Yrs. 577-44-1017 63 Georgia Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits Nas 2 No 8106 Comet Dr.Ft. Wash.MD. P.G. 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 8106 Comet 20744 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritel Status 1 Navar Marriad 2 Married 1 ☐ Yes 2 No If Yas, Giva Yaar or Datas: Specify: black 1 ☐ Yas 2 ☒ No Specify: 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) private construction 10 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) John Robert Britton Sr. Katie Mae Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, State, Zip Coda) Ruby N. Adams Sister 8106 Comet Dr. Ft. Wash, Md. 20744 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cometery, crematory or other placa) 20c. Location - City or Town, Stata Data 1 Burial 2X Cramation 3 Ramoval from Stata Chesapeake Crematory 5-22-98 Beltsville, 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Fecility Hodges and Edwards 21. Signature of Foreral Sarvice Licenses 3910 Silver Hill RD.Suitland, Md. 20746 cations that causad the daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset end Deeth 23a. Part1. Entar the disaasa, or on shock, or haart failura. List tmmediata Causa (Final disease or condition resulting in daeth) Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated avents Due to (or as a consequence of) Dua to (or as a consequance of): rasulting in daath) Last 23b. Did tobacco use contribute to the cause of deeth? 1. 28 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Woolcal Examinal must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mentel Hygiene. Important: if fram 27 is marked other than "natural", or items 234 and highery or other traumatic avent, the Wester Example must once.

Baltimore, Maryland 21215-0020

with the Maryland

Physician/Medical Examiner and I-transit ettending physician a l for use as the buriel-94 signed by the þ Completed Deed has certificate Be this

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Physician:

or Attanding

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death.

after Hospital 24 hours

After

2 funeral Certification: Diractor: /

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to madical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Home SARasidance 6 Other (Specify) 1 ☐ Yas XX No 1 | Inpatiant 2 | ER/Outpatiant 3 | DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Placa of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 - Homicide 29a. Cartifier XX Certifying Physictan: To the best of my knowledge, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated. Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and placa, and dua to tha ceusa(s) and mannar stated. (Check only one)

29c. Licansa number

29d. Date signed (Month, Day, Year)

8926 Woodyard Rd. Suite201

within 2

State Registrar

edical

31. Data filed (Month, Day, Year)

29b. Signature and the of or

30. Nama and



ss of person who completed causa of daath (Itam 23a) (Type, Print)

AidAK

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death **Physician** 2:40 P Timothy O'Neal Bonner MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ft. Washington Medical Center Ft. Washington Prince George's if Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1₩ 2□ F 30 212-06-8501 Yrs. Director 10-26-67 Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Merylend tent of Health and Mentel Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23s or 28s-1 show Examiner must be nothlisd at Maryland Prince George's Accokeek tyPyYes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Teresa Drive 20607 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Maritai Status 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 287 Merried Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: **Black** þ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) 2+Police Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Robert Bonner Peggie Reaves ဝ 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1301 Teresa Drive, Accokeek, Maryland 20607 Angela Bonner/Wife or othe 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 5/23/98 landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Facility J. B. Jenkins Funeral Home Downor 7474 Landover Road, Landover, Maryland 20785 23a. Part L Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medicai immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): USB signed by the at d be detached for Pert li. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed page 2 hes certificate 1 ☐ Yes 2 10 No 1 Tyes 2D No or Attending Physicien: funeral director. 25. Was case rafarred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 212 No 1 DInpatient P 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day Year) 27. Mannar of Death Certification: 28d. Describe how Injury occurred 28b. Time of 28c. injury at Work? 1 Naturai 5 Panding death. 2 🗆 No Investigation 1 ☐ Yes 2 Accident aftar death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be determined 28e. Place of injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homicide Filled 24 hours a Hospital 1 Cartifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a, Certifier pletely (Check only one) To the I 29b. Signature and title of cortified 29c. License number 29d. Date signed (Month, Dey, Year) o complated cause of death (itam 25) (Type, Print) 30. Name and addrass of person y Hilary Washington, M.D., 11701 Livingston Road, Suite 205, Ft. Washington MD 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

29c. License number

DIVIE

3001

29d. Date signed (Month, Day, Year)

HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar 29b. Signature and tile of cartifier

1. Date filed (Month, Day, Year)

MARIO

me end address of person who completed cause of death (Item 23a) (Type, Print)

JL.

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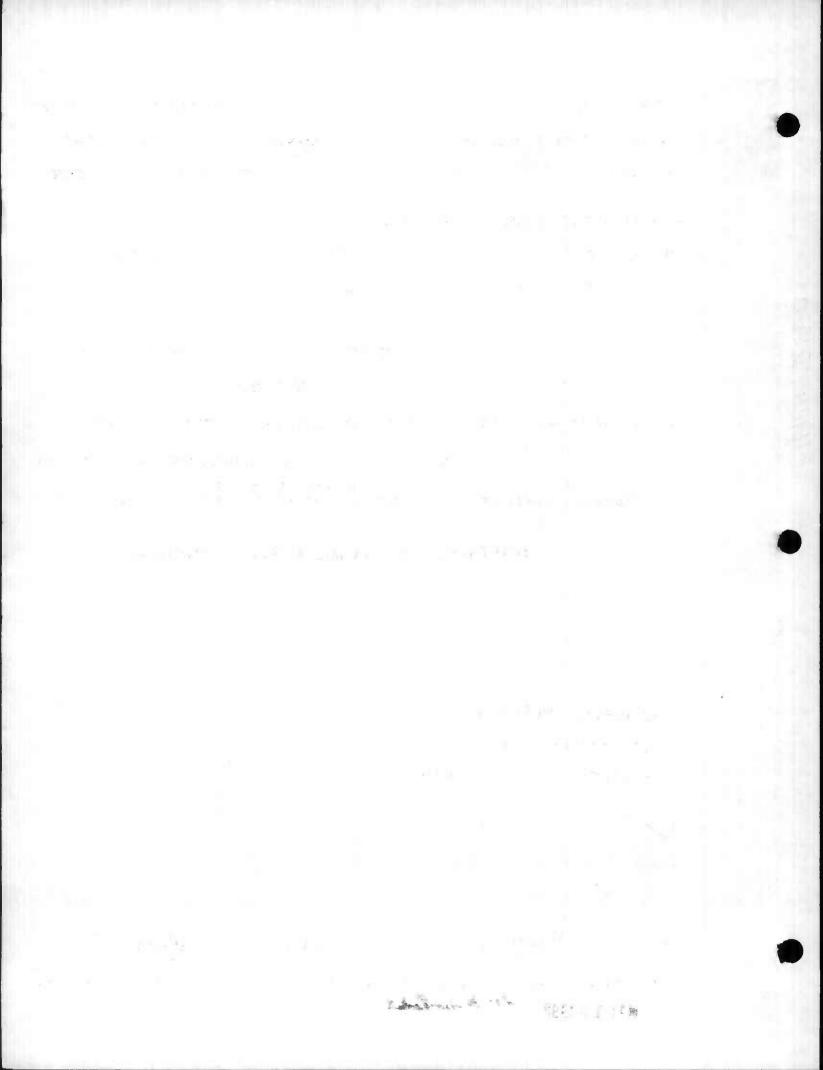
32. Registrar's Signature

DHMH 16 Ray 6/95



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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** 1998 mela 1:20 Am ryan la /Medical 4c. County of Death 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner FORT U Dashingtor umber 8. Sex 7. Aga (In yrs. last birthday) r If Under 24 Hrs. 8. Datie of Birth (Month, Day, Year) 9. Birthplace (Start or Foreign Country) If Under 1 Year Months Days 5. Social Sacurity Number **Funeral** Days 1□M 2月F 579-94-8104 Usual Rasidence of Dacedent Yrs. June 6, 1956 Director Alex, 10b. County 10c. City, Town or Location with the Maryland 10a State 10d. Insida City Limits 1 Nas 2 No Director Washinston D, # 202 101 Zip Coda notifie 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be U.S.A. 57. 20031 66 Gal ston Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Specify: þ lack 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Medical Materals ech. 10 HOOPIta 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Pages 1 and 2 should be nent of Health and Mental Boyc Pelores Lenard P. Ityden 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Important: If itsem 27 is m any injury or other traum pnce. 2704 Ft, Wash., Md
ta 20c. Location - City or Town, Stata Lumar Dr. Velores Doyd 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of Data 1 Surial 2 □ Cramation 3 □ Removal from State cematary, crematory or other place) 5-20 Alexandra la. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Home ewis tuneral 311 St. Alexandriqua. W. tatrick 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata intarvai Between Onset and Death Physician Immediata Ceusa (Final disaasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner (Co: 00010 The law requires that the death certificate be executed ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably Unknown ģ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was casa referred to medical axaminar? 26. Placa of Death (Check only ona) Hospitel: 1 Yas 2 No Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Dinpatiant 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 1 P Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident after deeth Director: 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datamined 3 ☐ Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the beat of my knowledge, daath occurred at tha time, date and piece, and due to the ceuse(a) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(a) and manner stated. To the I 29b. Signatura and title of certifial

29c. Licansa number

Bahram Rediace, MD 4467 Old Branch Ave., Suite 201 Temple Hills Md. 20748

legistrar's Signatura

29d. Data signed (Month, Day, Year)

State Registrar

31. Data filed (Month, Day, Year)

MAY 1 9 1998

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

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ì	Funeral Director	3 1	5. Social Security Number 578-01-0715	6. Se			rs. last birthday) Yrs.	If Under 1 Months	1	if Under Hours		6. Data of B	irth Pay, Year) 16,190	9. Birthi Coul	placa (State of try)	or Foreign
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	tha Marylar 28a-f show	tor	D. C.				WASHI									2 □ No
	h with tha	al Director	10e. Street and Number 1214 - E STREET, N. E.				10f. Zip Code 20002					10g. Citizen of What Country U. S. A.			ntry?	
020	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or items 23s or 28s-f show aumetic event, or Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 3 XWidowed 4 Dive	33.14	12. Was Dec Armed Fo 1 Yas If Yes, Gi Year or D	2 No	1	Vas Decede i Yes, speci I Ves 2	y Cuba	n, Maxicar	gin? (Sp i, Puerto	ecify Yas or N Rican, etc.)		aca - Americiack, Whita,		
21215-0020	d within 72 hours giena. r than "neturel", tre Medical Exa	Completed	15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)					ing	16b. Kind of Business/Industry			
land 2	s 1 and 2 should be filed within Haelth and Mental Hygiena. tem 27 is marked other than other traumatic event, trails	To Be Co	17. Father's Name (First, Mi	ddle, Last)	yrs. Ir	+	Mus	ICIAN				a (First, Middle IZABETI	e, Maidan Sum	MUSIC ame)		
e, Maryland	2 should and Men is marks	-	19a. tnformant's Name/Reta	tionship (7	ype, Print)		19b. Mailin	g Address	Street 8	and Numbe	er or Run	al Route Num	ber, City or Tov	vn, State, Zip	Coda)	
	1 and 2 Health em 27 i		BERNARD H. E	ARBOL	IR, JR.	20b	7205				u	PPER MA	ARLBORO 20c. Locatio			
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of European Se	_			P^{22}	NCKNE!	Addres -SP	ANGLI	R F	UNERAL				
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	2 2 8	Σ	29b. Signature and the of or	rtitier	_			29c.	Licansa	number	G		29d. Data sig	ned (Month,	Day, Year)	
	(12)		30. Name and addrass of pe	rson who c	omplated caus	se of death (It		Print)	211	214	50	PARKA	5/1	8/9	Ö	
1	Sta	te	31. Data filed (Month, Day,		VY→()/(Registrar's Sig	nature-	121 1	דרונ	VOV	74	MAKE	TY, UR	KKIVIN	C, MI	12077
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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** MAY 18,1998 ERVIN C. BENDER JR 2:36pm /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON P.G. COUNTY 8. Data of Birth (Month, Day, Year) FEB 11,1943 5. Social Security Number If Undar 24 Hrs. Birthplace (Stata or Foreign Country) 6 Sex 7. Aga (In yrs. last birthday) **Funeral** 1€M 2□ F Months Days Hours 55 415-64-7996 Director TENN Usual Rasidance of Dacedant the Maryland 10c. City, Town or Location 10d. Insida City Limits 10a Stata 10b County 28a-f ahon 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Medical Examiner must be notified at XXYas 2 □ No MD Director P.G. COUNTY BOWIE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4212 GLENN DALE RD 20720 Funeral UNITED STATES 12. Was Decedant Ever in U.S. Armed Forces? 1 ☑ Yas 2 ☐ No If Yas, Giva 14. Raca - Amaricen Indian, Black, Whita, atc. Was Decedani of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or item any Injury or other traumatic event. The 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) Elementery/Secondary (0-12) Collega (1-4or 5+) DENTIST HEALTHCARE 18. Mothar's Nama (First, Middla, Meiden Sumeme) 17. Fether's Name (First, Middla, Last) ERVIN C. BENDER, SR. CORNELIA WALTON 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) JOYCE BENDER /WIFE 1704 MICHIGAN AVE N.E. WASHINGTON D.C. 20017 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata ARLINGTON NATIONAL CEMETERY 6-3-98 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON VA 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility
ALEXANDER S. POPE FUNERAL HOMES e 7/085 5538 MARLBORO PIKE FORESTVILLE MD 20747 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medicai Immediate Ceuse (Final CARDIOMIOPATTAY disease or condition rasulting in daath) Examiner Examiner buriel-tran Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Ceuse (Disease or injury that initiated evants rasulting in death) Last and Due to (or as a consequence of): that the death certificate be exec P.O. Box 68760, physician Physician/Medicai the Dua to (or as a consequenca of): USB BS 23b. Did tobacco uss contribute to the cause of death? Part II. Other significant conditions contributing to daeth but not rasulting in tha undarlying ceuse given in Part I. signed by it 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, à 24b. Ware eutopsy findings available prior to 24a. Was an autopsy Completed peen performed? complation of ceusa of death? has page 2 2 No 1 ☐ Yas 2 ☐ No certificate 1 TYas Hospital or Attending Physician:
 A hours after death.
 Funeral Director: After this certific. funeral director, Be 25. Was cesa rafarrad to medicet axaminar? 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 0 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 1 Divatural 5 Panding invastigation 1 Tas 2 Accident 3 Suicida 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Phyelclan: To the best of my knowledge, daeth occurred et the time, date end place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to the ceuse(s) and manner stated. 29a. Certifier Medical To the Within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and addrass of person who completed ceusa of daath (Item 23e) (Type, Print) 7503 SURROTS Rd Clinton MD 20735/EMERGENCY DEPT.

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In the offunder R

State Registrar

31. Data filed (Month, Dey, Year)

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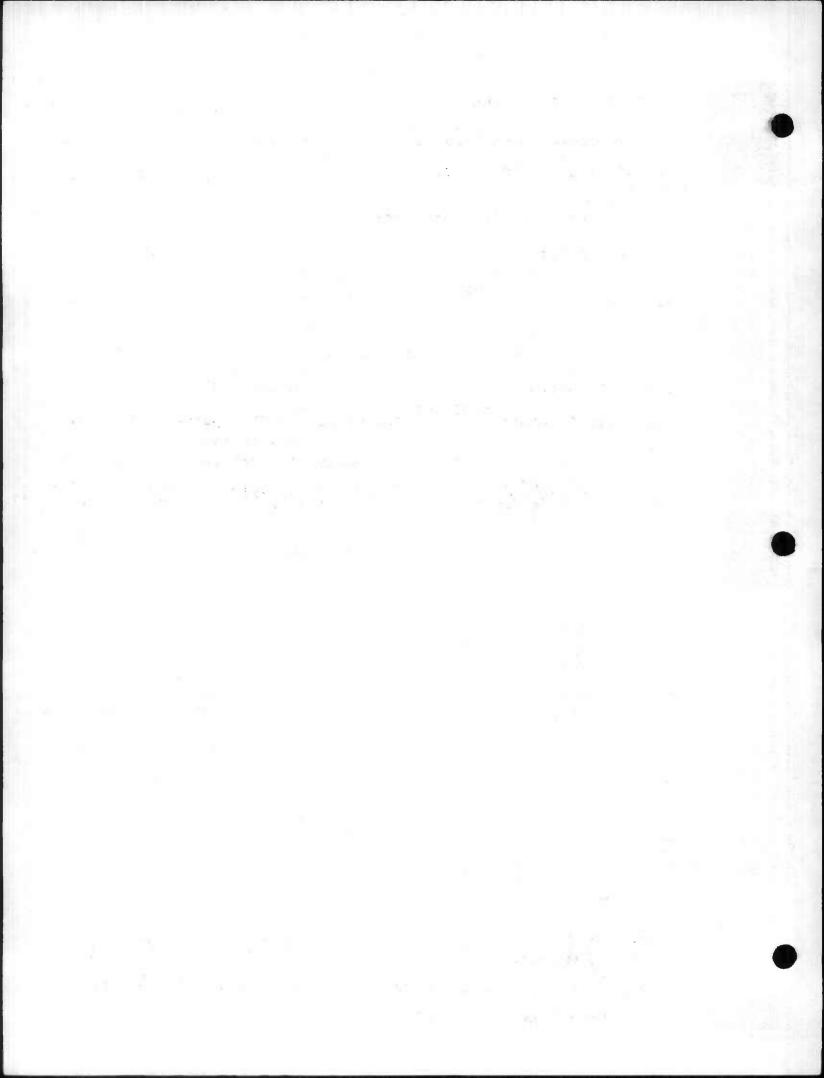
State of Maryland / Department of Health and Mental Hygiene

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21215-0020	n 72 hours after deeth with the Meryland "natural", or Items 23a or 28a-f show solical Examinat Durat be notified at	by Funeral	1 X Naver Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? Married 1 ☐ Yas 2 ☒ No If Yas Giva		 13. Waa Decedant of Hispanic Origin? If Yas, specify Cuban, Maxican, Put 1 ☐ Yas 2 ☒ No Specify: 		Specify Yas of No- into Rican, atc.) 14. He		, Whita, atc. White	
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Maryland	2 should be filed within and Mertel Hygiene. Is marked other than aumatic event, the Mertel Hygiene.	To B	Charles Hamilto	on Brown			Marie	Joseph	Morris		
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Σ	and 2 saith a n 27 is		Charles Carroll E	Brown - Brother							
e,	Health Health sem 27 I		20a. Method of Disposition	20h Pi	lace of Dispos	ition (Nema of		Data 2	Oc. Location - C	and Z	LU / & Z Stata
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			23a. Part 1. Entar the disease, or com	plications that causad the death	. Do not antai	r the mode of dy	imore Aven	or raspiratory arra	tsville st,	Apr	proximata
ď	Physician /Medical Examiner		shock, or heer teilura. List only Immediate Causa (Final disease or condition resulting in death)	a. Peril	raa a consequ	tis					arval Between set and Deeth
Box 68760,	deeth certificete be axecuted e ettending physician and of for use es the buriel-trensit	an/Medical Examiner	Sequentially list conditions, if any, leading to Immediata cause. Entar Undarlying Causa (Disaase or Injury that initiated events resulting in death) Last	b. I have Dua to (or c. Carrier	as a conseque	RAT C	Rt Co	lon.	Lynn	tin	
В	that tha deeth cer ed by the ettendir detached for use	Physician/	Part II. Other eignificant conditions	contributing to death but not rasu	ilting in the und	derlying causa g	ivan in Part I.	23b. Did tol	Dacco uee cant	ribute to the	cause of death?
<u>α</u>		by Ph						1 □ Ye	0 2 No	3 Probably	y 4 Unknow
Records,	aw requi	Completed t						24a. Was an perform	autopsy led?	availab	utopsy tindings ele prior to etion of cause h?
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o uo			27. Mennar of Death 1 Defural 5 Pending 2 Accident Invastigatio	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inj		28d. Dascribe ho			
Division	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	Certification:	3 Suicida 6 Could not be datarmined	28a. Place of Injury - At ho building, atc. (Specify	3	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)					
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	Mithii Foth	×	29b. Signature and title of certifier	~		29c. Licer	nse number	29	d. Dete signed	(Month, Dey,	Year)
	~		I HI W	(2)		00	7850		5/10	100	
	(1)		30. Neme and address of person who	completed cause at death (tree	220) (7: 7				110	10	
	6)		H.L. MARTE	completed cause of death (Item	7-1-1	Il a	uc . 7	AKON	A PAI	R.K.	Mos
	Sta Registi		31. Date tiled (Month, Day, Year) MAY 8 0 199	32. Ragistrar'a Signat	Rankell				. ,	/	. /

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Item: 27,28a-f per MEO G-764 10/22/98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CLAIRE INEZ BROWNELL May 25,1998 6:00 AM /Medical 4e. Fecility Neme (If not institution, give street and number) SPA-CREEK 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Anne Arundel Annapolis Genesis Eldercare of Annapolis 7. Age (In yrs. lest birthdey) | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 2XX Yrs. 425-36-7776 Director Sept.14,1926 Miss. Usual Residence of Deceden Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits must be notified at Md. Oueen Anne's Stevensville 1 ☐ Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21666 U.S.A. 400 Bay Drive items 23a death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ N.X. If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours efter of Hygiene. The matural, or item 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X Ø6 Specify: þ Specify: White 3-CNidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) permit. Peges 1 and 2 should be filled with Department of Health and Mental Hygiene Important: If Item 27 ie marked other that any Injury or other traumatic event, in a sonce. C.I.A. Systems Analyst 17. Fethar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middla, Malden Surneme) Anita Reuthven Edward E. Smith 19e. Informant's Neme/Reletionship (Type, Print) Daughtes. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Emily B. Emmons 7209 Horseshoe Ct., Quinton, Va. 23141 20b. Pleca of Disposition (Name of cametery, cramatory or other piece) May 29 peter 998 20c. Location - City or Town, State 20a. Method of Disposition 1 DABArial 2 Cremetion 3 Removel from Stete Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 22. Name end Address of Fecility
Fellows, Helfenbein & Newnam Funeral Home
408 S. Liberty St., Centreville, Md. 2161 21. Signeture to Funeral Service Licen 23a. Part1 Enter the desise, or combilications that causes the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or he in failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finei disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical the Due to (or es a consequenca of) for use as ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown signed be det Records. ģ 24b. Wara eutopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? page 2 s certificate 1 Yes 2 A 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificatively filled in by the funeral director, Be 25. Wes case referred to medical 28. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residenca 8 Other (Specify) Certification: To 1 Yes 2 TNo 27. Mennar of Deeth 28b. Time of Injury 28e. Date of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes R No X Accident April 1998 Unk. Subject fell 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 400 Bay Dr. 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide A 24 hou. Stevensville, Md. edical To the Hosp within 24 hou To the Funer completely fil 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner stated. 29b. Signeture and title of cartifie 29d. Dete signed (Month, Dey, Year) D72036 30. Nerpe, and address of person who completed cause of deeth (Item 23e) (Type, Print) 2108 D. Darato Deine Club, MD 21619 sany 32. Registrar's Signature State MAY 2 6 1998 Julia Davidson-Randelle Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month hilbert reekmore Norris Mai 6:20 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Cambridge Hospital Dorchester GENERAL Dorchester If Undar 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 6. Sax 220-52-8756 100M 2□F Months Days Yrs. Makyland Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. tnsida City Limits 1 TYas 2 No Maryland Dorchester ambridge 10e. Street end Number 10g. Citizen of What Country? 538 Lane 2161 CONORdS 14. Race - Amaricen Indian, Biack, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 1 □ Navar Married 2 □ Marriad 1 Yas 2 No Spacify: Specify: Black 3 Widowed 4 Divorced 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Educetion (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) CRab Picker Seafood Industry 17. Fathar's Name (First, Middla, Lest) 18. Mothar's Name (First, Middla, Maldan Surnama) CREEKMORE 19b. Mailing Address (Straat end Number or Rural Routa Number, City or Town, Stete, Zip Coda) 2121/ ester 19e. Informant's Neme/Relationship (Type, Print) 4405-Falls Bridge DR. BaltiMore Maryland
Data 200. Location - City or Town, Stata OOPER Sandra 20e. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 5/30/98 Cambridge, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Address of Facility 21. Signatura of Funaral Sarvice Licensaa Home Funeral HENRY 2/6/3 510Washington St. Cambridge, Maryland anelle Henry 23a. Part | Enter the disease, or complications that caused the distinct Do not enter the mode of dying, such as cerdiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximata Intervel Batwaan Onsat and Death tmmediete Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceusa (Disaasa or Injury that initieted events rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2□ No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was en eutopsy completion of ceusa of death? 2 0 No 1 Yas 1 Yas 2 No 25. Was cesa refarred to madicel axaminar? 26. Placa of Daath (Check only ona) 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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nd Mental Hygiene. marked other than

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Department of important: if eny injury or = 6

Director

Completed by Funeral

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Pages 1 end 2 should be filed within 72 hours after death with the Marylend ont of Health end Mental Hygiene.

21215-0020

Baltimore, Maryland

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The law requires that the death certificete be executed

Hospital or Attending Physician:

To the

Division of Vital Records. P.O. Box 68760.

this efter death. Director: Af the in by within 24 hours e To the Funeral D completely filled

Physician/Medicai by Completed Be Certification: To

Examiner

29a. Cartifian

27. Mannar of Daath

Naturel 2 Accidant

3 Suicide

4 Homicida

30. Nama and addrass of person who complated ceuse of deeth (Item 23a) (Type, Print)

28c. Injury at Work?

Certifying Physician: To tha best of my knowledge, death occurred at the time, deta end place, and dua to tha cause(s) end manner as stated.

Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the ceusa(s) and mannar stated.

Location (Straet and Number or Rural Routa Number, City or Town, Steta)

28d. Dascribe how injury occurred

Cambridge, m

29b. Signatura and tola of certifian

5 Panding invastigation

6 Could not be datarmined

29c. Licansa number

X.

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Day, Year)

State Registrar

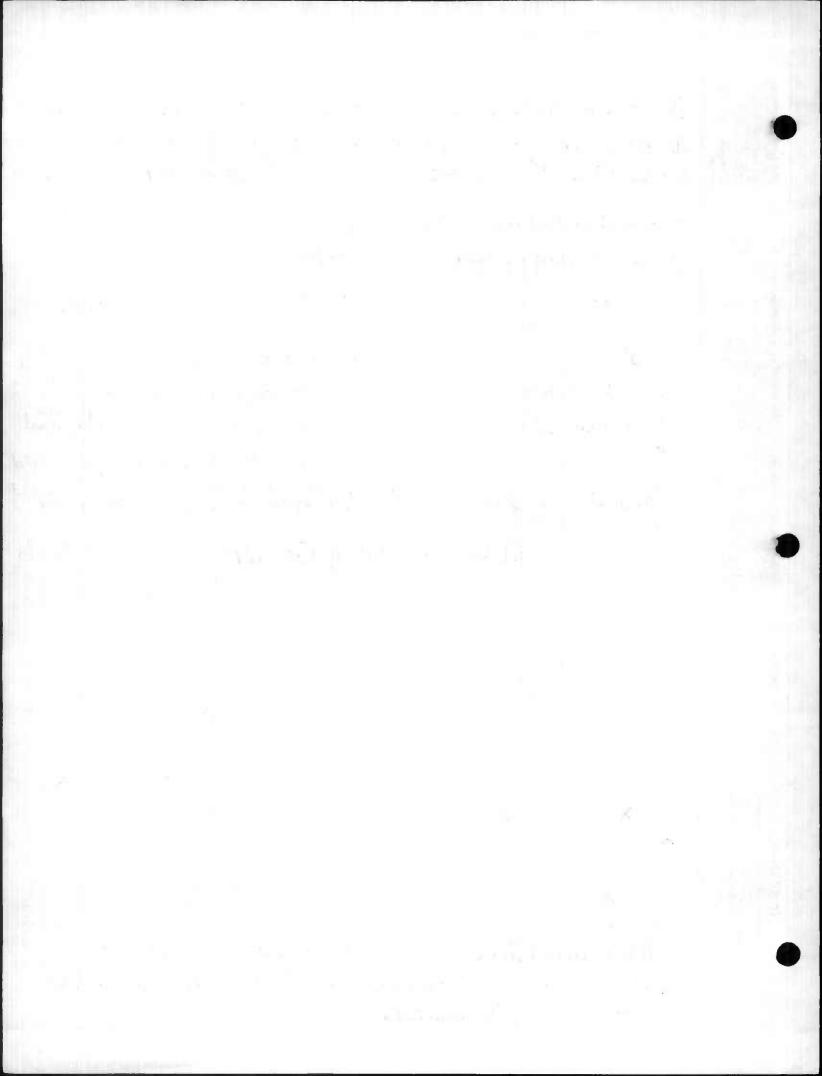
Medical

31. Deta filad (Month, Day, Year)

32. Bagistrer's Signatura

28b. Time of

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Spacify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month May 22 1998 8:30 a.m. James Edward Cifaldo 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Residence: 409 South Juniata Street Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplaca (Stata or Foraign Country) Maryland 7. Age (In yrs. last birthday) Days Months 1⊠M 2□ F 64 215-30-5879 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 409 South Juniata Street 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yas 2 □ No If Yes, Give Korean Year or Dates: War Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Nevar Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: Specify 3 Widowed 4 Divorced White War 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Price Brothers Elementery/Secondary (0-12) Eight Years College (1-4or 5+) Aberdeen, Maryland Forklift Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Angelo Cifaldo Angelina Ciarlo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Domonic J. Cifaldo (Brother) P.O. Box 102, Perryville, Maryland 20b. Place of Disposition (Name of 20a Method of Disposition Data 20c. Location - City or Town, State cemetery, cremetory or other place) 1X Burlal 2 ☐ Cremation 3 ☐ Removal from Stata 5/26/98 Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Brookview Cemetery 21. Signature of Funeral Service Licenses 22, Name and Address of Facility Lee A. Patterson & Son Funeral Home 23a. Part. Enter the disaase, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heer feiture. List only one ceuse on each line. Approximate Intervel Between Onsat and Death UX 423 Immediate Cause (Final 0 disease or condition resulting in deeth) 261 woma me Due to (or as a consequence of): Due to (or as a consequence of) significant conditions, contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | N6 3 Probably 4 Unknown 4100 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Was an autopsy 1 | Yes 2 | M 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ope) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death

Physician /Medical **Examiner**

nding physician and use as the buriel-transit

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or Attend after death Director:

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

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Medical

P.O. Box 68760,

Records,

Division of Vital

Physician

/Medical

Examiner

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Completed

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other treumatic event.

Baltimore, Maryland 21215-0020

the Maryland

death v

Examiner Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Physician/Medical

1 Neturel

2 Accident

4 Homicide

31. Date filed Month, Dey, Year)

MAY 26

3 ☐ Suicide

25. Was cese referred to medical examiner?

28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

11 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ststed.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner steted. 29b. Signatu and titla of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year)

5 Pending Investigation

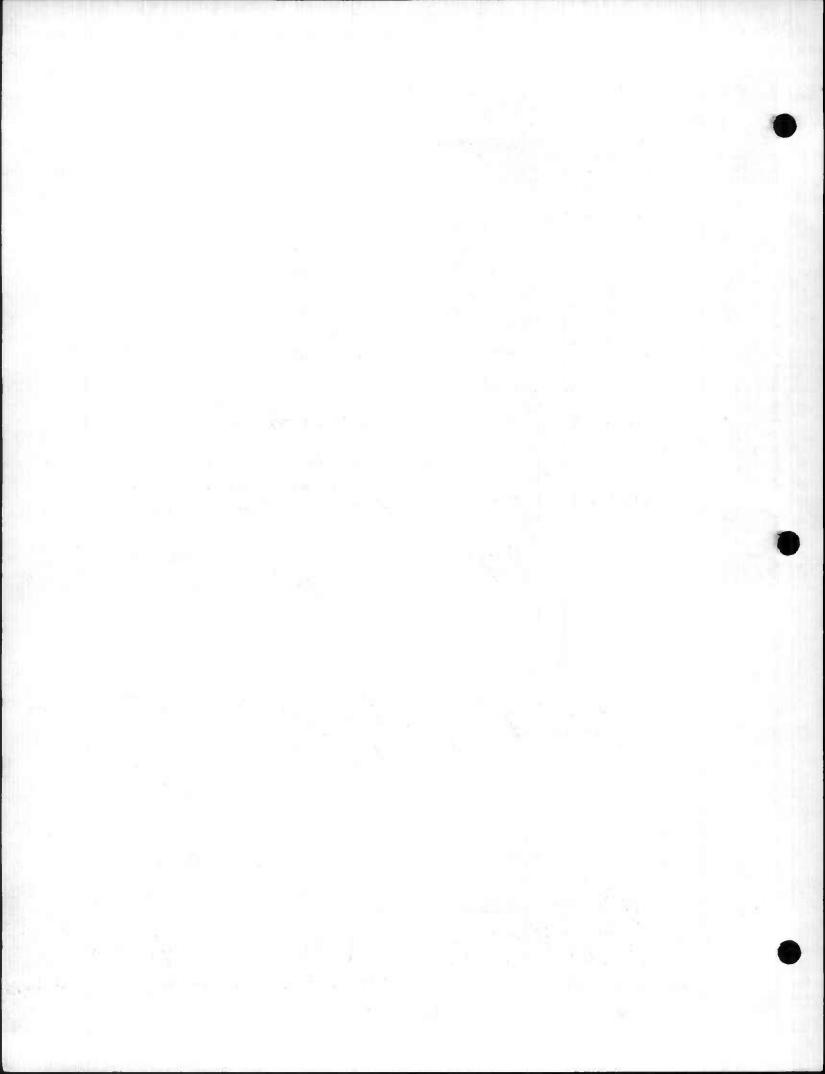
6 Could not be determined

cause of death (Item 23a) (Type, Print)

Union Ave. Havre de Grace, Masons

10+1 UP

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Death Month Yaai Asbjorn MAY 1998 Bertel Christiansen 24 4a. Fecility Nama (If not institution, giva straet and number) 4b. City, Town, or Location of baath 4c. County of Death Union Hospital of Cecil County E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) 1 X M 2 □ F Yrs. 83 177-28-9534 Denmark Usuel Rasidanca of Dacedant 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yas 2 1 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 263 Old Chestnut Road 21921 United States 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Merried 2 ☑ Marriad 1 ☐ Yes 2 ☒ No Spacify: If Yas, Give Year or Datas: White 3 ☐ Widowad 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) Eiemantary/Secondary (0-12) Collega (1-4or 5+) 12 Carpenter Hospital 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) Christian Christiansen Tinka (Maiden name unknown)

20b. Placa of Disposition (Nama of camatery, cramatory or other placa)

R.A. Ferris Crematory

22. Nama and Addrass of Facility Crouch Funeral Home

19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Coda)

Data May 26

127 South Main Street, North East, MD 21901

1998

20c. Location - City or Town, Stata

West Chester, Penna.

Approximeta Intarval Betwaen

24b. Wara autopsy findings evailable prior to

completion of causa of death?

1 ☐ Yas 2 ☐ No

263 Old Chestnut Road, Elkton, MD 21921

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. Stata

Director

Funeral

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Completed

Be

19a. Informent's Neme/Ralationship (Type, Print)

4 ☐ Donation 5 ☐ Othar (Specify)

21. Signature of Funeral Service Ucenses

20e. Mathod of Disposition

Karen E. Christiansen/Spouse

1 ☐ Buriai 2 🖾 Cramation 3 ☐ Ramoval from Stata

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examper must be notified at

the Maryland

filed within 72 hours after death with

nd Mental Hygiene. marked other than

.. Pagas 1 and 2 should be fill timent of Haaith and Mental H tant: If Item 27 is marked oth jury or other traumatic even

permit. Page Department of Important: If any injury or

21215-0020

Baltimore, Maryland

Records, P.O. Box 68760,

Thristiansen, Asbjorn

detached for use es the buriel-transit page 2 should the funeral director.

certificate hes

After this

within 24 hours eftar deeth To the Funeral Director: A

filled in by

or Attending

24. Part1. Entar tha diseasa, or complications that causad tha daath. Do not enter tha moda of dying, such es cardiec or respiretory errast, shock, or haert failura. List only ona causa on each lina. eremo Vascular Accident Immadlata Cause (Final diseasa or condition rasulting in daath) Physician/Medical Examiner pertenson Sequentially list conditions, if any, leeding to immediata causa. Entar Undarlying Cause (Disaasa or Injury that initieted events rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24a. Was an autopsy 1 Yas 2 No Be 25. Was casa rafarred to medical 26. Pleca of Daath (Check only ona) Hospital: 1 Umpatiant 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 8 ☐ Othar (Specify) Certification: To 1 | Yas 2 | N6 27. Manner of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Invastigation 1 Naturei 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datermined 3 ☐ Suicida 28e. Plece of Injury - At home, farm, straat, factory, office building, etc. (Spacify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida 1 Certifying Phyelcien: To the best of my knowledge, daath occurred et the time, date and place, and dua to the ceuse(s) and manner as steted.

2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year)

Registrar

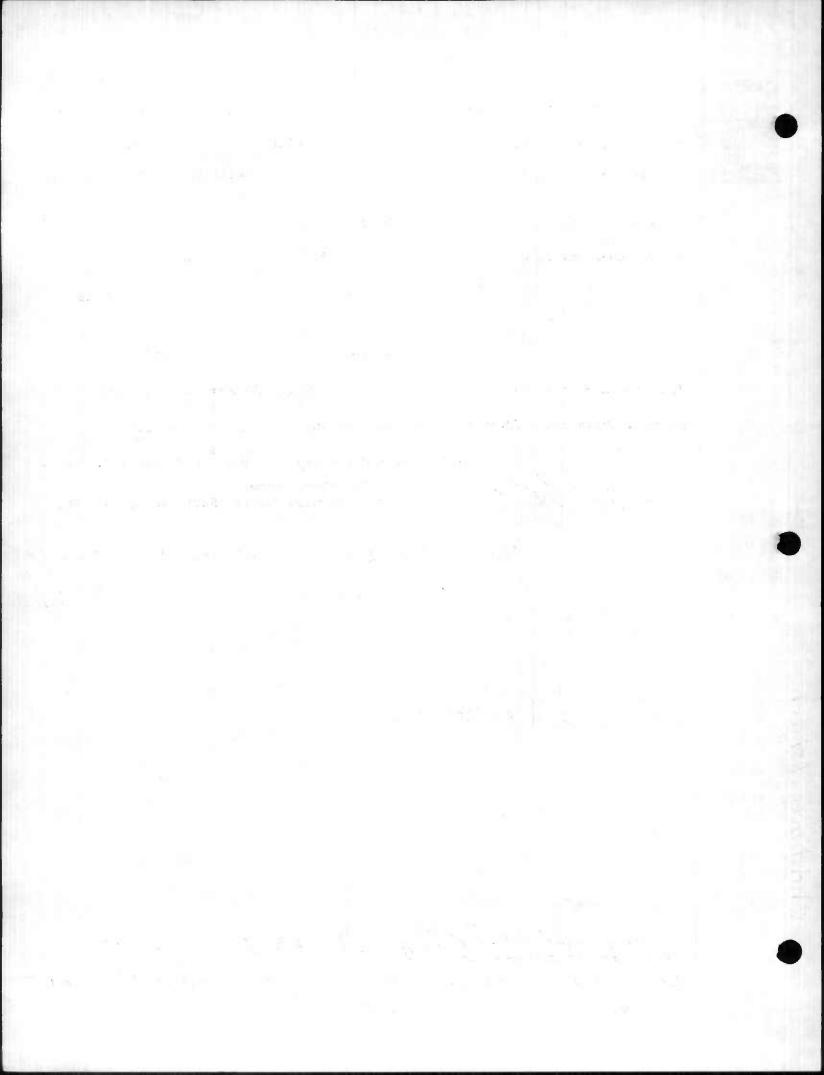
MAY 26

JAYANTILAL

30. Name and ecoress of person who complated cause of death (Itam 23a) (Type, Print)

PATELMO 123 Singerly Ave, ELKTON, MD21921 32. Registrer's Signatura

DHMH 16 Rev 6/95



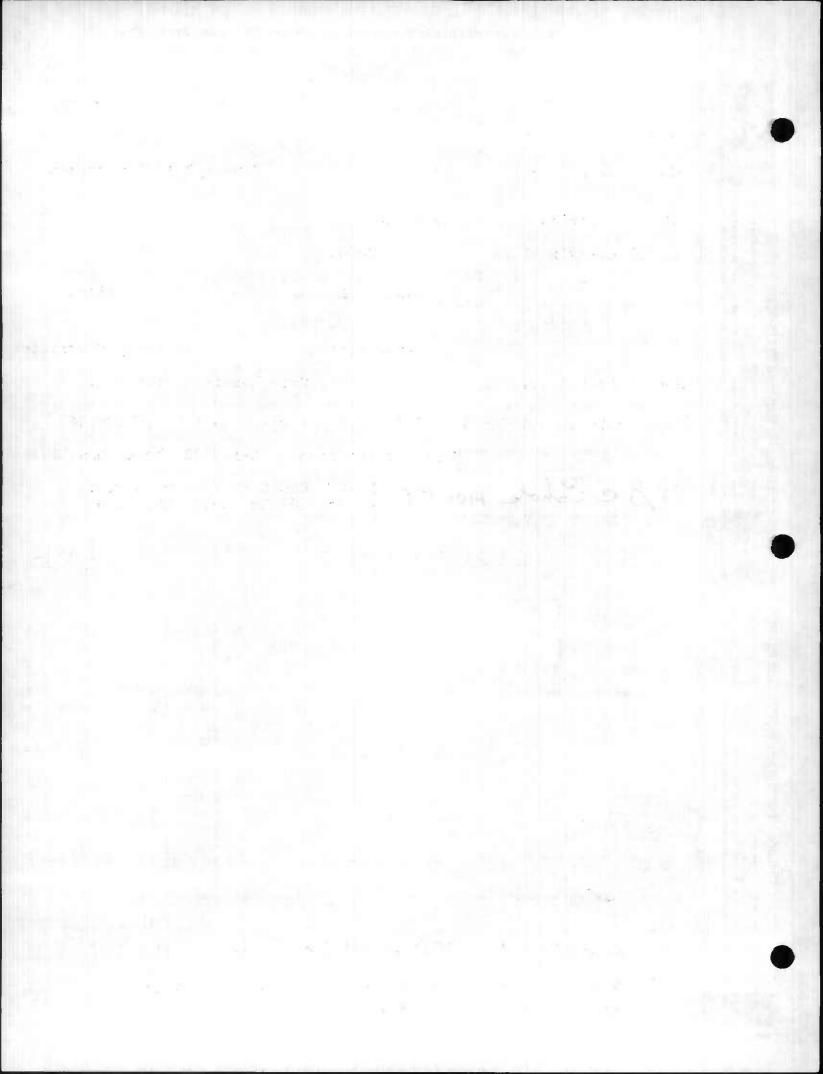
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1, Decedent's Neme (First, Middle, Last) 25 **Physician** MAY COLE, SR. JOSEPH WADE 1998 :30am. /Medical 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 11851 LIZZY'S PLACE LA PLATA CHARLES | Months | Deys | Hours | Min | January 3, 1930 | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 and | Mary 1 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months 10XM 20 F 214-30-0770 68 Yrs. Director Usuel Residence of Deceden with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic avent, the Medical Examinar mast be notified at 1 Yes E No Director Charles La Plata MD 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 11851 Lizzy's 20646 USA Place Funeral death 12. Wes Decedent Ever in U.S. Armed Forces?

12 Yes, 2 No If Yes, Give Yeer or Detes: 1951-1953 1 Yes 2 No Specify: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Rece - American Indien, Bleck, White, etc. 11. Maritel Status filed within 72 hours efter Hygiene. 1 Never Married 2 Married Black altimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sanitary Commission Pipe Fitter 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Peges 1 end 2 should be file Depertment of Health and Mentel Hy Important: If Item 27 is marked oth any linjury or other traumatic avent potes. 17. Fether's Neme (First, Middle, Last) Be Mary Lessie Dorsey Cole Joseph Daniel Cole 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 11851 Lizzy's Place La PLata, MD. 20646 Mary Beatrice Cole/Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other place)
Maryland Veterans 20c. Location - City or Town, Stete 6-1-1998 Cheltenham, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility AREHART-ECHOLS FUNERAL HOME P.A. MO0 17 P.O. Box 567 La PLata, MD.20646 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical LYMPHOMA WITH METATASIS Examiner Due to (or es e consequence of) Examiner physician and s the buriel-trensit requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) 98 950 0 signed by the el 23b. Did tobacco uss contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? certificate hes peged 1 Xes 2 | No Physicisn: 25. Wes cese referred to medical exeminer? funerel director, Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Tresidence 6 Other (Specify) 1 Yes 2 10 Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of fnjury 27. Menner of Deeth 28c. Injury et Work? or Attending 1 Neturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No heral Director: / 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Direc 4 D Homicide Hospital 24 hours Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner steted. 29e. Certifier edical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number MAY 26, 1998 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) KRISHAN MATHUR, M.D., P. 0. BOX 2729, LA PLATA, MD MAY 2 7 31. Dete filed (Month 32. Registrer's Signature State whi Davolear Revolate Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle Last) 2. Data of Death Month Vasi **Physician** 12450 arah hristian 95 18 /Medical 4a. Facility Nama (If not institution, giva street and number) 606-Laren 8D 4b. City, Town, or Location of Death 4c. County of Death Examiner Health Services Largo, Md 20772 Large Hunder & Hrs. Manar P.G. Count (ane 5. Social Sacurity Number Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 10 M 28F 84 Director Warrenton, VA. 236-42-6942 Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be nictified at 1 ☐ Yas 2 No Director Washington, D.C. 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7723 Alaska Avenue, N.W. 20012 U.S.A Funeral death 12. Was Decedant Evar In U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.

The procrams: If them 27 is marked other than "natural", or then eny injury or other traumatic event, the Medical Exercises 2006. Black White atc. 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Black þ 3 Widowed 4 □ Divorced Yaar or Datas: Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Housekeeper Cleaning Industry 5th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Ernest Long Fannie Lambert 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Lewis E. Christian/ Son 719-59th Place Fairmont Height's, Maryland 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 NBurlal 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Spacify) Glenwood Cemetery 5-26-98 Washington, D.C. 22. Nama and Address of Facility
Sterling Funeral Service 21 Signature of Funeral Sarvice Licansee 1601 Kenilworth Avenue, N.E. Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician Carcinoma Juteus /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequanca of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 2 NO been signed by should be detact 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed **page 2** certificata has 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Homa 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 5 Rasidance 8 Othar (Specify) this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Pending invastigation Natural 1 Yas 2 No 2 Accidant

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

20715

Division of Vital Records, P.O. Box 68760, Attending Physicien:

il or Attending Pi after death. I Director: After ti Hospital 24 hours a Funeral D Te the Hosp within 24 ho To the Fune completely f

Registrar

Medicai

Rakesh Arora, M.D. 1400 Gallant Fox Lane, Suite 222 Bowie, Maryland 31. Data filed (Month, Day, Year)

29b. Signature and titla of certifian

3 Suicida

29a. Cartifiar (Check only one)

4 Homicida

32. Registrar's Signatura

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)

LECTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

MAY 21

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6 Could not be datamined

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath 3. Tima of Death 8:20 AM Month **Physician** CASH OGER /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** PRINCE ARINER 7. Aga (in yrs. last birthday) If Unda 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) Birthpiaca (Stata or Foraign Country) **Funeral** 1X M 2□ F Months Days Hours 92 217-09-5882 Director 10-01-1905 Timberlake, NC Usuai Residanca of Decedant with the Maryland 10b. County 10a. Stata 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinat must be not in ad at 10d. Insida City Limits MD Prince George's Palmer Park Director TY Yas 2 No 10e. Straat and Number 10f. Zip Code 10g. Citizan of What Country? 7743 Normandy Road 20760 USA death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, Whita, atc. filed within 72 hours efter 1 Navar Marriad 2 Married ☐ Yas 2 💢 No Yas, Giva Saltimore, Maryland 21215-0020 1 ☐ Yas 2 💆 No Specify: Black Specify: by 3 X Widowad 4 ☐ Divorced Yaar or Datas: eted 15. Decadant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Comple end Mental Hygiene. Coilege (1-4or 5+) National Park & 8 Laborer Planning Syc. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) 2 should be fi Be James Cash Celia Claxton 19a. Informent's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Pages 1 end 2 sh Department of Health end Important: If item 27 is m any injury or other traum Cynthia Brownlee/daughter 7743 Normandy Road Palmer Park, MD 20a. Method of Disposition 20b. Placa of Disposition (Nama of Date 20c. Location - City or Town, Stata camatary, cramatory or other placa) 1 X Buriai 2 ☐ Cramation 3 ☐ Ramovai from Slata 4 Donelion 5 Othar (South) 5/19/98 | Landover, MD Harmony Memorial Park 22. Nama and Addrass of Facility of Funeral Service Licensee Tyrone J. Young Funeral Services 719 Kennedy Street, N.W. Wash., DC 20011 not antar tha moda of dying, such es cardiec or raspiratory arrast, Approximata Interval Batween Onsat and Daath **Physician** /Medical Immadiata Causa (Finel marea disaasa or condition rasulting in daath) Examiner Vascular Diience Examiner physician and s the buriel-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarfying Causa (Diseasa or injury that initieled events rasulting in daath) Lest P.O. Box 68760, 90 Physician/Medical Dua to (or es a consaquanca of): 88 ettending Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records. by 24b. Were eutopsy findings available prior to Completed 24e. Wes an autopsy performed' complation of causa of death? page 2 certificate has 1 ☐ Yas 2 ☐ No 1 Yas 2 No Division of Vital Be 25. Was case rafarrad to medical 26. Pieca of Death (Check only ona) axaminar' Other: 4 Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatian | 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Attending 1 Naturat 5 Pending investigation s ofter death. 1 Yas 2 No 2 Accidant in by the 3 Suicida 6 Could not ba 28a. Ptace of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homlcide To the Hospital or within 24 hours eff To the Funeral DI 1 Certifying Physician: To the bast of my knowladge, daeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier completely (Check only one) 29b. Signatura and title of cartifiar 29c. Licansa number 29d. Deta signed (Month, Day, Year)

30. Nama and address of person who completed causa of death (Item 23e) (Type, Print)

ANDREW KYNDRAFM.D, 8317 CHEVRY LARC, LAUREL, Md 20707

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State Registrar

MAY 1 8 1998

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	Was case refer	red to medical				26. Place of D	eath (Check only one)			
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27.	Menner of Death 1 XXNatural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	M 2	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how			
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		nome, farm, stree	t, factor	y, office	28f. Location (Stree City or Town, S	t and Number tete)	r or Rural Route	Number,
29	a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowninar: On the basis of examination and manner steted.	owledge, death o ation and/or inve	occurred stigation	at the time, date and pla , in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) end men and placa, ar	ner es stated. nd due to the ca	use(s)

29c. License number 29d. Date signed (Month, Day, Year) OCME MAY 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Theodore King M.D.

State Registrar

edicai

31. Date filed (Month, Day, Year)

RIN 01

29b. Signeture and title of cartifier

32. Registrar's Signeture

note: fework 12 mm sink tablifier 4 fe

Examiner

Funeral Director

"natural", or items 23s or 28s-f show soical Examiner must be notified at traumatic event, tre Medical nd Mental Hygiene. marked other than Peges 1 end 2 should be 1 Department of Heelth (Important: if Itam 27 is any injury or other tre

Catherine Cantrell

Physiclan /Medicai Examiner

The law requires that the death certificate be executed the burial-trar P.O. Box 68760, 88 esn signed by Records. of Vital this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Division Hospital or Attending

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CATHERINE BISHOP CANTRELL 18, May 1998 6:00 PM 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death The Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 10 M 25F Days Yrs. 214-28-4032 Aug. 20, 1915 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 SYes 2 No Completed by Funeral Director Md. Queen Anne's Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Kidwell Avenue 21617 U.S.A. 11. Meritel Status 12. Was Dacedent Evar in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notify Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3√Widowed 4 □ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highest grade completed) Wash.DC Public School Elementary/Secondary (0-12) College (1-4or 5+) Riggs Nat'l. Bank Teacher & Banker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be C. Tilghman Bishop Ethel Bartlett 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Bishop-Niece 4 Londonerry Dr., Easton, Md. 21601 May 22 pate 1998 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetary, crematory or other place) 20e. Method of Disposition Description | 2 □ Cremation | 3 □ Removal from State | 4 □ Donation | 5 □ Other (Specify) Chesterfield Cemetery Centreville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home S. Liberty St., Centreville, Md. 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intervat Between Onset end Death I well Immediata Causa (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Physician/Medicai Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings aveilable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examinar Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 1 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar 31. Date filed (Month, Day, Yaar)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 2 0 1998

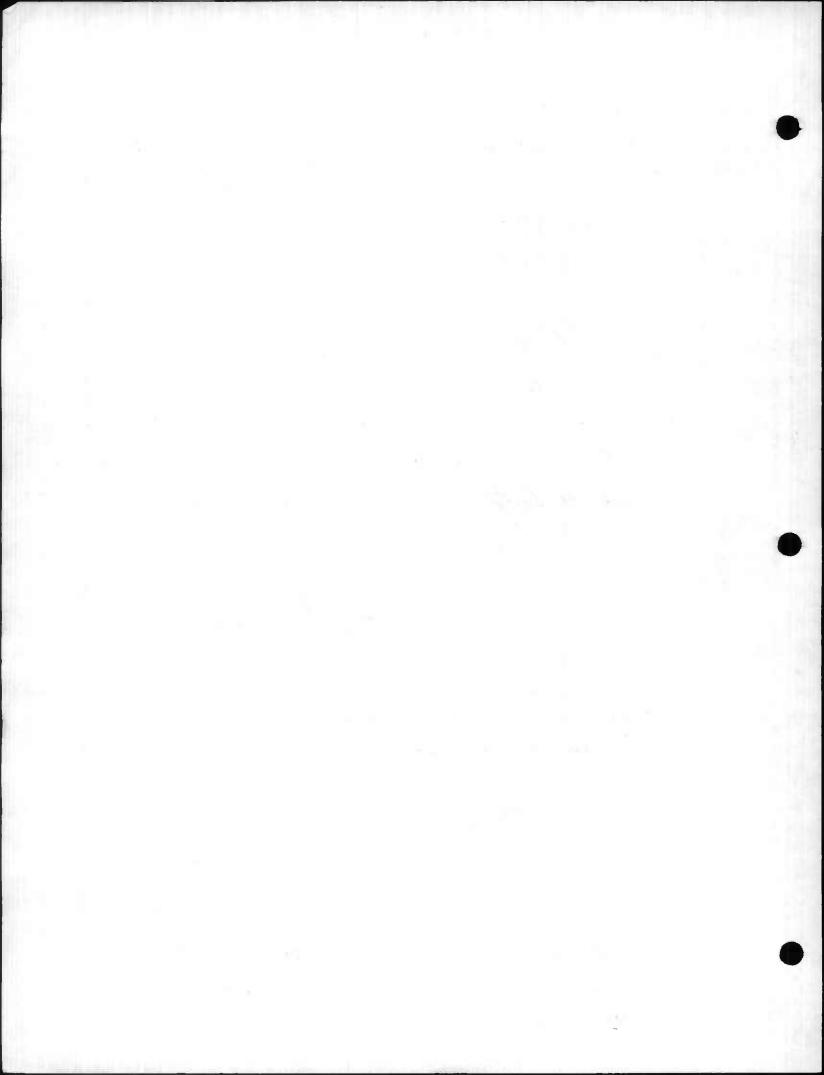
32. Registrar's Signatura

Julia Davidson

William H. Wood, M.D.; 506 Idlewild Ave., Easton, Md. 21601

DHMH 16 Rev 6/95

the



State of Maryland / Department of Health and Mental Hygiene

ALPHA	YOHYA	DIAL

ASP Items: 23 part I,27 per MEO G-760 6/9/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Vear **Physician** ALFA YAYA DIALLO MAY 1998 8:19 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months 8 Days 10XM 20 F Hours 215-51-5303 10-3-97 Director Maryland Usual Residence of Deceden the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at PG 1 Ves 2 □ No Maryland Director Hyattsville 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 8135 15th St. 20783 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indian. 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after t. Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or flen any Injury or other traumatic event Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) None Elementary/Secondary (0-12) College (1-4or 5+) None 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Ousmane Fatoumata Binta Diallo Diakite 19a. Informent's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5431 Macbeth St, Hyattsville, Md. Oumar P. Bah 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State George Washington Cemet. 5-22-98 Adelphi, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature et Funeral Service Licensee 22. Name and Address of Facility UNIVERSAL MORTUARY INC. 411 Kennedy St, N.W., Washington, D.C. 23a. Part1. Enter the disease, or complications thel caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical fmmediete Ceuse (Final SUDDEN INFANT DEATH SYNDROME disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner certificata be axecuted the bunal-transit and Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical Due to (or as a consequence of) USB BS attending loc the 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. detach signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Were eutopsy findings evalleble prior to completion of ceuse of deeth? 24a. Was an autopsy Completed peen has page 2 1 Yes 1 Tyes 2 No 2 | No certificata Attending Physician: director, 25. Was cese referred to medicel Be 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 No Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☑ DOA this funeral 27. Menner of Deeth XX Naturat 28a. Date of tnjury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending investigation tniury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completaly filled in by the fune 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

Registrar

ennis 31. Dete fited (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

MAY 26

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 hute mo 32. Degistress Signature Randall

Christe o

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year) 16,1998

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At the most and the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth May **Physician** 1998 7:30AM Luther Andrew Della, Sr. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Charles 7209 Glen Albin Rd. La Plata 6. Sey-1 ☐ M 2 ☐ F 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Sept. 6, 1909 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Deys Months Hours Maryland 88 Yrs. 212-01-7580 Director Usual Rasidance of Dacedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be not liked at Director 1 Yes 2 No MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? With 20646 7209 Glen Albin Rd. USA death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Example. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 Widowed 4 □ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Transport Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sophie Ann Rice Della Edward Morris Della 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Della/Son P.O. Box 1571 La Plata, Md. 20646 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burlal 2 Cremation 3 Removel from State 5-29-98 Dentsville, MD. United Methodist 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Home P.A. MOO945 P.O. Box 567 La Plata, MD. 20646 lec 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Batween Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner sician and bunel-transit Sequantially list conditions, if any, laading to immediata ceuse. Enter Underlying Ceuse (Disease or Injury that initiated avants resulting in daeth) Last Due to (or as a consequence of) ettending physician I for use es the burie Records, P.O. Box 68760. Physician/Medicai ed by the etter deteched for u Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa givan in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown been signed should be d þ 24b. Ware autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medicel examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Vas 2 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Day Year) he Hospital or Attending P n 24 hours efter death. 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Certifying Phyalcfan: To the best of my knowledge, deeth occurred at the time, deta and place, and due to the ceuse(s) and mannar as stated.

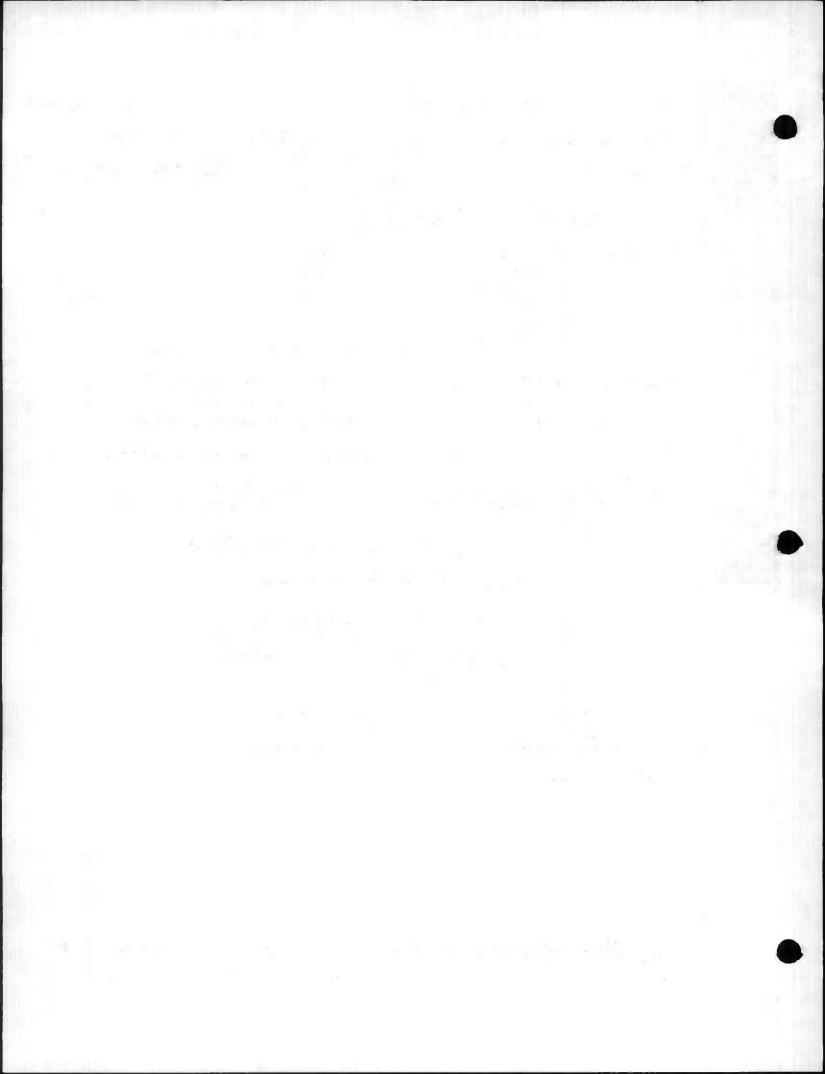
2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, and due to the ceuse(s) and manner stated. 29a. Certifian Medical (Check only one) To the within 2 To the 29b. Signature and title of perfile 29c. License number 29d. Date signed (Month, Day, Year) Paul E. Pritchett, Sr.M.D., P.C. P.O.Box 1317 La Plata, MD. 20646

State Registrar 31. Dete filed (Month, Day, Year)

MAY 2 7 1998

32. Begistrary Signature

Audien Rendall



		\$	State of Marylan		artment of			ene g. No. 98	17489
		1. Decedent's Name (First, Middle, Last)					2. Dete of Deeth		3. Time of Death
п	Physician /Medical	Jean Ve	ronica Da	avis			May 21	Day 1998 Year	1:55 PM
ķ.,	Examiner	4a Fecility Neme (If not Institution, give str					or Location of Deeth	4c. County of Deeth	
		Southern Mary				Clin		Prince G	
	Funeral Director	214-00-3000	7. Age (In yrs. 73	last birthday Yrs.	Months Deys				plece (State or Foreign ntry) ylanu
	and w	Usuel Residance of Decedent 10e. Stete 10b. County	10c. Cit	y, Town or L	ocation				10d. Inside City Limits
	danyi faho	Maryland Prince Ge	orge's		Upper	Marlbor	0		1 TYes 2 □ No
	Tec 128	10e. Street end Number			10f. Zip Code		10	g. Citizen of Whet Cou	intry?
	3a o	3305 Melwood Re	oad			20772		ÜSA	
	vurs after death with the Manylan Fill, or items 23a or 28a-f show Enabline must be noutled at by Funeral Director	11. Maritel Stetus	Wes Decedent Ever in U Armed Forces?	,S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Rece - Amer Bleck, White	
0	or he	1 Never Married 2 Merried	1 ☐ Yes 210 No If Yes, Give		1 ☐ Yes 2 ☒ No		, , , ,		lack
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21215-0020	led within 72 hours after death with the Maryland Yglone. Typlone. It, the than "natural", or items 23e or 28e-4 show it, the theorem fraist be notified at the theorem and the confidence of the theorem of the completed by Funeral Director.	15. Decedent's Educat (Specify only highest grade of	lon om <i>pleted)</i>	16e. Dece	edent's Usuel Occu e kind of work done DO NOT use retin	ipation e during most of v ed)	vorking	6b. Kind of Business/li	ndustry
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	be filed within 72 ho hal Hyglene. In other than "nature event, the Madical Be Completed	17. Fether's Neme (First, Middla, Last)				18. Mother's N	lame (First, Middla, M		
lar	should be filed and Mental Hygh marked other imatic event, To Be Cc	Benjamin Hage:	r			V	ictoria Al	ice Washin	gton
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		James Davis Sr./H						boro, MD 2	
altimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti once.	20e. Method of Disposition 1 △ Burial 2 □ Cremetion 3 □ Ren			osition (Neme of emetory or other plants			t0c. Location - City or 1	
tim	men tant: jury	4 ☐ Donetion 5 ☐ Other (Specify)	Re		ction Cen		5/26/98	Clinton, M	aryland
Bal	permit. Page Department of Important: If any Injury or page.	21. Signeture of Funeral Servica Licansee	1	2	2. Name end Addi		Funeral Ho	me	
_	002.00	Nancy A.	Percente		7474 La	ndover	Road, Land	over Marvl	and 20785
ı		23a. Pert1. Enter the disease, or complice shock, or heert feilure. List only one	tions thet caused the deel causa on each lina.	h. Do not er	nter the mode of dy	ring, such es card	liac or respiretory erre	st,	Approximete Interval Between Onset and Death
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	Examiner	disease or condition rasulting in death) a.	MIK	100	W. C.		,		4-1-
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ó	be executed ician and burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Entar Undarlying Ceuse (Diseese or Injury	Keollo.	60	ullo	Ce			
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ds	The law requires the state has been signed, page 2 should be Completed by	EMM .					24e. Was er		Vara autopsy findings
CO	w req	,01.					perform		veilable prior to completion of cause of daath?
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ta	certificata has rector, page 2 Be Comp	25. Wes casa rafarred to medical				28. Place of I	Deeth (Check only one		
>	Attending Physician: or death. ector: After this cartificial by the funeral director, iffication: To Be (examinar?	pital: 1 Inpatient 2	ER/Outpetie	ent 3 DOA	ther: 4 Nursin	g Home 5 Resida	nce 6 Othar (Spec	rify)
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Division of Vital Records,	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	4 Homicide determined	28e. Placa of Injury - At h building, etc. (Speci		treet, factory, office	9	City or Town	reet end Number or Ru , Stete)	rai Houte Number,
	o the Hospital or Attending Physician: The law infinit 24 hours after death. • the Funeral Director: death is certificate has perpletely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Certifying Physic	lan: To the best of my kno	wladaa daa	th occurred at the	time date and ale	ace and due to the ce	usea(c) and menner as	etated
	in 24 hour he Funer pletely fil		r: On the basis of exemine end menner stated.						
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in Medical Cert	29b. Signeture end title of cartifier		.1.1	29c. Licer	nse number	25	d. Dete signed (Mont/	n, Dey, Year)
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	Registrar	MAI 22 155	and the same	UNIS .					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme, (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** /Medical 4b. City, Town, or Location of Deg 4e Facility Neme (If not ligstitution, give street and number) Examiner MONTGOMEN If Under 24 Hrs. 8, Dat If Under Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 584-32-8242 1 M 2 F **Director** Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2018 Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11 Meritel Stetus 1 ☐ Yes 2 ☐ If Yes, Give Yeer or Detes: 1 Never Married 2 Married 2 No 1 Yes 2 No Baltimore, Maryland 21215-0020 HISPANIC by 3 ☐ Widowed 4 ☐ Divorced DOMINICAW Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me College (1-4 or 5+) Elementery/Segondery (0-12) Hygiene. 4 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Symame) Be end Mental 2 19b. Malling Address (Street and Number of Rural Royte Number 19a. Informant's 20b. Plece of Disposition (Name of cemetery, crematory or other place, Department of Health a Important: If item 27 is any injury or other tra 20c. Location - City or Town, State 20e. Method of Disposition Deté 1 Buriel 2 □ Cremetion 3 ☐Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical tmmedlete Ceuse (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Box 68760 P.O. been signed by the e should be deteched t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Was an autopsy Completed is certificata has director, pege 2 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Unpatient 3□ DOA 2 ER/Outpetient this funarai 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After Naturel 5 Pending Investigation 2 No death. 1 Yes 2 Accident oftar deatl Director: 6 Could not be determined 3 ☐ Suicide Funeral Directo 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier Mcartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner steted. ž To the To the I 29b. Signeture end title of co 29d. Date signed (Month, Day, Year) 2

State Registrar 31. Dete filed (Month, Day, Year)

30. Name end eddress of person who cor

SILVER SPENG, HIS 20910 CARLOS E. COVACEVARS 32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth May 16, **Physician** 1998 E1va L. 12:00 Noon /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** 109 Cree Dr. Prince George's Forest Heights If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplece (Stete or Foreign Country)
May 27, 1939 North Carolina 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** Deys Months 1 M 2 F 244-60-3183 58 Director Usuel Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelin and Meritel Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-4 show any fujury or other traumatic event, its Medical Examiner must be norified and once. 10e Stete 10b. County 1XXYes 2 □ No Directo Prince George's Forest Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20745 USA 109 Cree Dr. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married Specify: Black 1 Yes ≱OXNo Specify: Baltlmore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Induatry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 5+ Registered Nurse Health Profession 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be David H. Smith Eula Thompson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 109 Cree Dr., Forest Heights, Fredrick Danzy/Husband MD, 20745 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 Other (Specify) Benbow Chapel Cemetery 5/22/1998 East Bend, North Carolina 22. Name end Address of Fecility George P. Kalas Funeral Home, P.A. Part Prior the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, MD 20745, about of heart failure. List only one cause on each line. ala Approximete interval Between Onset and Deeth **Physician** EROSCIEROTIC DISEASE Immediete Ceuse (Finet diseese or condition resulting In deeth) /Medical Examiner Due to (or es e consequence of):
DERTEN STON Examine physician and s the buriel-trensit death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest OVASCULAR DISEASE Box 68760, Physician/Medical S 950 23b. Did tobacco use contribute to the cause of death? Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evalleble prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? certificate has b lirector, page 2 sl 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home Nursing Home 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To foxes 2□ No this funeral 27. Manner of Deeth 1 2 Neturel 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending Investigation Hospital or Attending 1 ☐ Yes 2 ☐ No deeth. Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) in 24 house. the Funeral Director filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature end oted cause of death (Item 23a) (Type, Prim 32. Registrer's Signeture State Four d'audien Registrar

DHMH 16 Rev 6/95



The Cart Street Contract of

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yee **Physician** May 3:50PM 16 1998 .Timmie Deas /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpleca (Stete or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Days Months 1X M 2□ F Director 60 Dec. 14, 1937 South Carolina 251-56-4902 Usuel Residence of Decedent 10e. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No District of Columbia Washington Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Coda 3302 East Capitol St., N.E. 20019 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bieck, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nt: If Nem 27 Is marked other than "natural", or Ne ☐ Yes 2 No Yas, Giva 1 Nevar Married 2 Married 1 Yas 2♥ No Specify: Specify: Black py 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elamantary/Secondary (0-12) Coilega (1-4or 5+) 9th Truck Driver Private 18. Mothar's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Joe Deas, Sr. Beulah Denkins 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Maggie M. Deas - Wife 3302 East Capitol St., N.E.; #B, Wash., D.C. 20019 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Crametion 3 Removal from State 6 permit. Pege Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Pisgah Bapt. Ch. Cem. 5/23/98 Rembert, S.C. 22. Name end Address of Facility Stewart Funeral Home 21. Signature of Funerel Servica Licensee 23a. Part X Enter the disease, or complications that caused the death. Do not anter tha mode of dyling, such as cardiac or respiratory errest, shock or heart feiture. List only one cause on each line. 4001 Benning Rd., N.E. Wash., D.C. 20019 Approximate tntervel Between Onsat end Death Physician /Medical Immadiete Ceuse (Final Acute Myocardial Infarction
Due to (or es e consequence of): diseese or condition resulting in deeth) Examiner Examiner OVONGVY physician and s the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Physician/Medical Due to (or es e consequence of) USB 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? signed by vtersion 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Wes en eutopsy performed? page 2 should Completed 1 Yes 1 □ Yes 2 □ No certificate 25. Wes case referred to medical axeminer? director, Be 26. Place of Death (Check only one) Hospitei: 1 Inpatiant Other: 4 Nursing Homa 5 Residenca 8 Other (Specify) 10 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun Neturel 1 Yas 2 No 2 Accident 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner stated. edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MD. D. 25802 30 Name and address of person who completed cause of deeth (Item 23e) (Type, Print) AMJAD RASUL MD 4700 Be 4700 Berwyn HTS 104 College Park, Md State

Registrar

33 Registrer's Signetura

the Marylend

death

Baltimore, Maryland 21215-0020

requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Hospital or Attanding Physician:

305- 0 8 4AM

Ta .

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1,00 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 355 AM DOOLEY ROSELYN MAY 4c. County of Death 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) Annapolis Anne Arundel Anne Arundel Medical Center 8. Dete of Birth (Month, Dey, Year) Jan. 31, 1923 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. Birthplaca (Stete or Foreign Country) 5. Social Security Number 1 M 2 F Days Hours 219057151 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yas 2 No Oueen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Beachside Dr. 21666 U.S.A. 12. Was Decedant Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 2 No If Yes, Give Year or Datas: 1 Navar Married 2 Married 1 ☐ Yes XXNo Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Night Clubs Elementery/Secondary (0-12) College (1-4or 5+) Entertainer/Dancer 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John E. Kreager Thelma M. Hinkel 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Straat end Number or Rural Route Number, City or Town, State, Zip Code) James E. Dooley-Husband 406 Beachside Dr., Stevensville, Md.21666 20b. Place of Disposition (Name of cemetery, cremetory or other piece) May 29, 1998 20c. Location - City or Town, State 20a. Method of Disposition XXBurlal 2 Cremation 3 Removal from State Stevensville Cemetery Stevensville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd., Chester, Md. 21619 Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or reart failure. List only one cause on each line. Approximele Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC LARGE CELL LUNG CANGER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceusa. Entar Undarlying Causa (Disease or injury that initiated avents resulting in deeth) Last Due to (or as a consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

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Md.

Directo

Funeral

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Completed

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Funeral

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with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health end Mental Hygiene. Important: if Itam 27 is marked other than "naturel", or items 23s or 28s-4 show very fujury or other treumstic event, the Medical Examples must be northed at once.

altimore, Maryland 21215-0020

attending physician and for use as the bunal-transit use as t 3 page 2 s has certificate

requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Hospital

After this

24 hours efter death.

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completely

Examiner Physician/Medical þ Completed funeral director, Be Certification: To filled in by

2200 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deat 28b. Time of 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida

29e. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifie

29c. License number

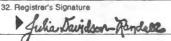
29d. Date signed (Month, Day, Year) MAY 23 1998

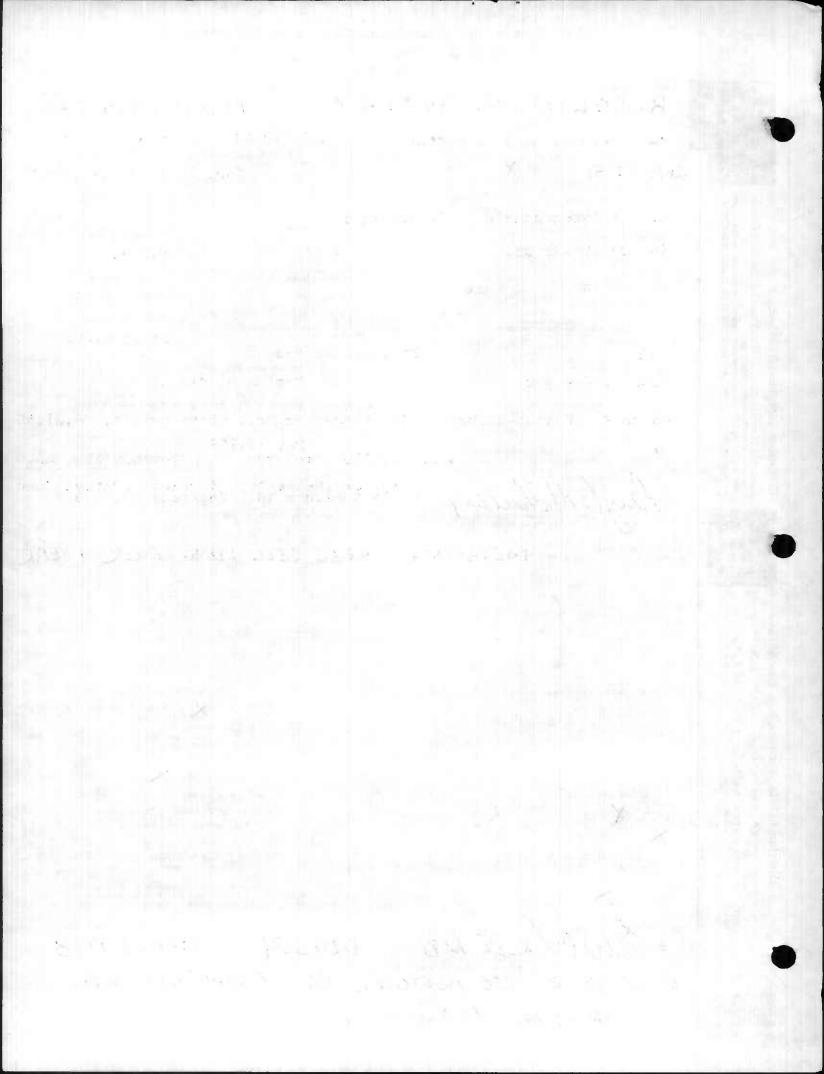
30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print)

ANNAPOLIS MD 31. Date filed (Month, Dey, Year)

Registrar

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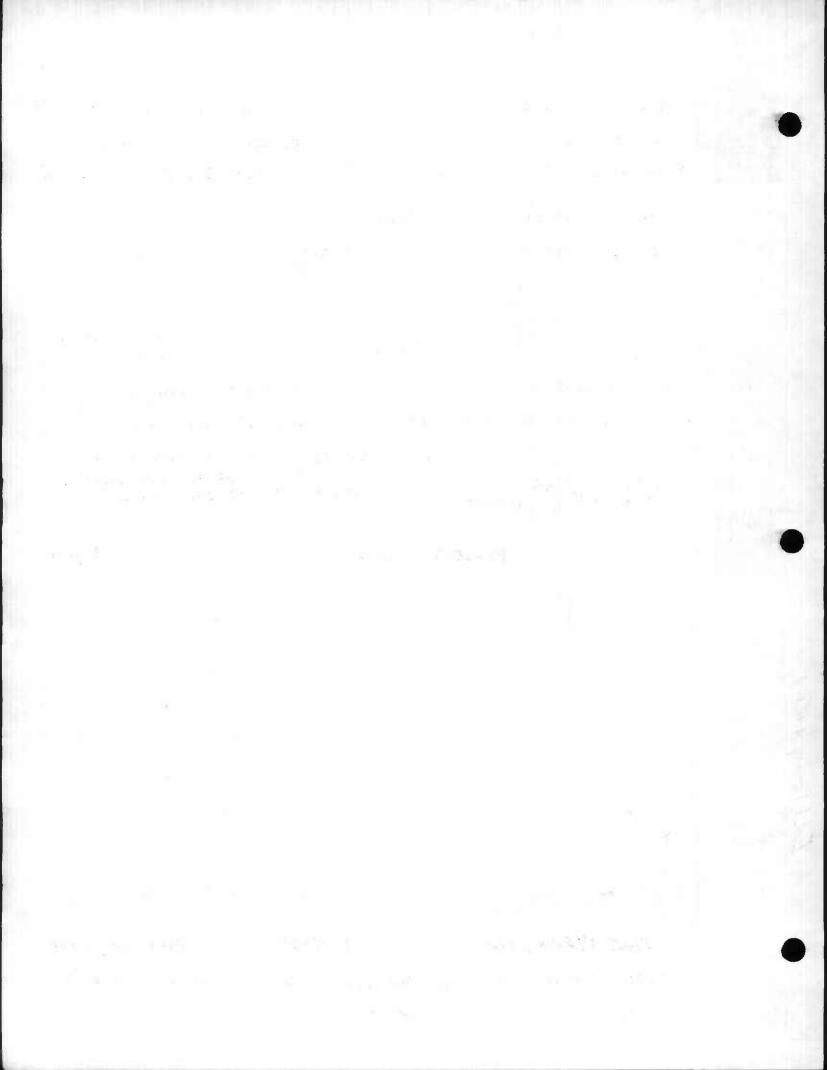




State of Maryland / Department of Health and Mental Hygiene

giene 98 17494

						Certificate o	f Death		Reg. No.		11774
	V 14.		1. Decedent's Neme (First, Middle,	Last)				2. Date of D	eeth		3. Time of Death
- 1	Physici		Harry G. El	1ison				Month May 1	9, 199	Year	8:00 PM
	/Medio Examir		4a. Facility Name (If not institution,)		4b. City, Town, or L			-	
	LAAIIII	iei	103 Brown S						-		
-	Francis				ge (In yrs. last b	irthday) if Under 1 Yes	Elkte ar If Under 24 Hrs.	8. Date of Bi	rth	Ceci	
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	_		Usual Residence of Decadent		01			ep. Z	3,1917		Maryland
	fand		10a. Stete 10b. County		10c. City, Tox	vn or Location				1	Od. inside City Limits
	f sh	5	Md. C	eci1	1	Elkton					1 Ves 2 No
	n the Maryland r 28a-f show	Director	10e. Street end Number			10f. Zip Code	6		10g. Citizen of	Albeit Cour	A.
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	ours after death v el', or items 23s Exemper must	Funeral	11. Maritel Stetus	12. Was Decedent Armed Forces		If Yes, specify Co	l Hispanic Origin? (Sp Jban, Mexican, Puert	Rican, etc.)		ck, White,	en Indian, etc.
20	s aft	by F	1 ☐ Never Married 2√ Married 3 ☐ Widowed 4 ☐ Divorced	IT Yes, Give 4	No	1□ Yes 2ŌN	o Specify:		Specif	v: TAT	hite
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77	her her	ပိ	12. 17. Father's Name (First, Middle, La	not)			_	o /Final Middle	Ground		
and	d d of	Be					18. Mother's Nam			ŕ	
<u> </u>	2 should be filed within 72 hours after death with the Manjand and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be nutried at	P	Clayton Ell					-	Bouch		
Maryland	12 st and ls m		19a. Informant's Name/Relationship			b. Mailing Address (Stre					
	s 1 and 2 should be filed within 72 hc Health and Mental Hygiene. tem 27 is marked other then "natur other traumatic event, ins Mederal		Mildred C. El	lison, Wi		03 Brown	Street,				
or o	Pes 1		20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3	□ Removal from State	cemete	of Disposition (Name of ary, crematory or other p		Date	20c. Location	City or To	own, State
Ē	Pag ant:		4 ☐ Donation 5 ☐ Other (Spe		Elkt	on Cemete	ery 5,	/22/98	Elkto	on,	Md.
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once.		21. Signature of Funeral Service Lic	onsee		22. Name end Add	lress of Fecility	259	E. Mair	n St	reet
0	20 = 20		15/	App	4	Gee Fune	eral Home	Elkt	on. Md	21	921
11/0	-		23a. Part 1. Enter the disease, or co	omplications that cause	d the death. Do						Approximete
	Physician		shock, or heart failure. List of	nly one ceuse on each i	ine.		,,	,			Interval Between Onset end Deeth
	/Medical		Immediate Cause (Final	-	4 4-						
	Examiner		disease or condition resulting in deeth)	a. [100		Cancer					s years
		ē			Due to (or as a	consequence of):					
	pe risu	Examiner		b. —		1				1	
-5	certificate be executed ding physician and ise es the bunal-transit	xal	Sequentially list conditions, if eny, leading to immediate		Due to (or as e	consequence of):					
760	bee	aj	cause. Enter Underlying Cause (Diseese or Injury that Initiated events	C							
68760,	phy:	edicai	resulting in death) Last		Due to (or es a	consequence of):					
×	iat the death certifica d by the ettending phielached for use es the	\$		■ d							
2- B	death e etten ed for u	Physiclar									
80	es that the death gned by the ette be detached for	ysi	Pert il. Other significent conditions	contributing to death b	ut not resulting	in the underlying cause	given in Pert I.	23b. Did	tobacco use co	ntribute to	o the cause of death?
3 9	hat ti d by detac							1□	Yes 2 KNo	3 Pro	bably 4 Unknown
15,		by								T	41
oro	aw requir 1s been si 2 should	ted							s en eutopsy ormed?	ev	ere autopsy findings ailable prior to
700	aw 1s b	pie								of	mpletion of cause deeth?
0 00	The I	Completed						10	Yes 2 No	10	☐Yes 2☐No
Vital Rec	vician: The certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only	one)		
ELLisoni	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ inpatie	ent 2 ER/O	utpetient 3 DOA	Whor:		idenca 6 □Oth	er (Snecil	(v)
20	Phys eral di		27. Manner of Death	28a, Date of init	rv 28h	Time of 28c. in			how injury occur		<i>y</i> /
1116	Attanding Ir death.	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	y Year)		/ork? □ Yes 2 □ No				
isi	Attandi r death. ctor: A y the fu	fica	3 Suicide 6 Could not	be	iurv - At home, f	arm, street, factory, offic	8	28f. Location	(Street and Numi	oer or Rura	al Route Number.
Š	or Attand after death Director: / d in by the	Certification:	4 ☐ Homicide	building, et	c. (Specify)	arm, street, factory, offic			wn, State)		
	Hospitel 24 hours : Funeral riely filled	ai C	29a. Certifier 1P4 Certifying	Physician: To the hest	of my knowledg	e, death occurred at the	time date and place	and due to the	cause(s) and m	2000000000	tatod
	Hos 24 h Fur etely	edicai		aminer: On the basis o	f examination e	nd/or investigation, In my	opinion, death occur	red at the time	, date and place,	and due to	the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signeture end title of certifier	and mariner St	w.ou.	29c 1 ice	nse number		29d. Date signe	d (Month	Dev. Year)
	To vit		Monte Mile	ALA MAN			_		A.A.A.		
	16			/			-44783		1749	50	, 1998
-	10		30. Name and address of person wh								
			Mante Anna								7
			MONTE MAKO			WEST MICH	I STREET	E	LKTON	MD	21921
	Sta Registr		31. Dete filed (Month, Day, Year)		er's Signature		i street	-, E	LKTON,	MD	21921



State of Maryland / Department of Health and Mental Hygiene

					,	Certifica		Death		eg. No.	8	7495
П	Physici	an	1. Decadant's Nama (First, Middla, L						2. Data of Dear Month	th Day	Yaar	3. Time of Death
	/Media		Carleton		Elliott				May 13,			10:45 a.m
	Examir	er	4a. Facility Nama (If not institution, g)			4b. City, Town, or I		4c. County		
			2110 Brooks Dr.		no Almana Inchie	(ab ab a) If I look	er 1 Year	Forestv If Under 24 Hrs.		Princ		0
ı	Funeral Director		577-48-9065	Sax 1 Q M 2 □ F	ge (In yrs. last bi	Yrs. Month		Hours Min.	8. Data of Birth (Month, Day Feb. 23		9. Birthpla Count Wash	aca (Stata or Foreign ry) ington, D. (
	show	1	Usual Rasidanca of Dacedant 10a. Stata 10b. County	0 1-	10c. City, Tow					3.	10	d. Insida City Limits
	he M	ecto		George's	ror	estvill						XXYas 2□No
	th with t	Funeral Director	10e. Streat end Numbar 2110 Brooks Dr.	#106		101. 2	ip Coda 20	747		og. Citizan of \ United		
21215-0020	72 hours after death with the Maryland "netural", or frems 23a or 28a-f show solcal Examiner must be notified at	by	11. Marital Status 1 ☐ Navar Marriad 2 ☐ Married 3 ◯▼Widowad 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yas 2 If Yas, Giva Yaar or Datas:	?		edant of Fecify Cubi	lispanic Origin? (S an, Maxican, Puart Specify:	pecify Yas or No- o Rican, atc.)	Biad	e - Amarica ck, Whita, a	tc.
5-0	72 ho	Completed	15. Dacedant's I (Spacify only highast g	Education	16a	. Decedant's Us	uai Occup	eation during most of wor	king	16b. Kind of B	usinass/Indu	ustry
121	C .	nple	Eiamantary/Secondary (0-12)	Collage (1-4or	5+)	lifa. DO NOT	usa <i>ratire</i>	d)	n.i.ig	Corror	nment	
	illed with Hygiene. other than		12	4		U.S. Ma	rsnaı		11 1 1			•
Maryland	S is b >	Be	17. Fathar's Nama (First, Middla, Las						ne (First, Middla, I	Maidan Suman	na)	
Ž	d 2 should be the and Mentel I is marked of traumatic eventer	To	Clarence Ellio				(0)		Thomas	0: -		
Ma	tra tra		19a. fnformant's Name/Ralationship					and Number or Ru Cove 01				
e,	other tr		Robin Brown/ Da 20a. Mathod of Disposition	ugiitei	20h Place o	of Disposition /A	ama of	T		20c. Location -		
Baltimore,	y or		1⊠ Buriei 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Space		Ft.	Lincoln	Ceme	tery 5		Brentwo		
Bal	permit. Pa Departmen Important: any injury once.		21. Signatura of Funarai Sarvica Lice	ensaa M/O	-	Ale	xande	ss of Facility	e Funera	1 Homes	Mary	land 20747
			23a. Part1. Enter the diseasa, or conshock, or heart failure. List on									Approximate
	Physician /Medical Examiner	J.	Immadiata Causa (Final disessa or condition rasulting In death)		1 att		/p	Mon	mye	m bc k	SM	intarval Batwean Onsat and Death
	pet tist	nine		b. pros	The 11C		CVe	1 HY	puter	2)10~		
90,	icate be executed physician and s the burial-transit	il Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	. mit	Dua to (oras a	consaquance of): ~ c s	ìs			1	
ox 68760,	75 FR 65	VMedical	that initiated avents rasulting in death) Last	a. Rhei	Dua to (or as a	consaquance of	•	1 61	SCHL			
Box	eath cert	clar	Death Observation and the						1			
P.O.	the d	Physician/M	Part II. Other algnificant conditiona		out not rasuiting I	In tha undarlying	causa giv	ren in Part i.				the cause of death?
S, P	requires that the de been signed by the should be detached	by	1)-alcoh	Kism					1 7	●● 2□ No	JAJ Prob	abiy 4 🗆 Unknown
Division of Vital Records,	e law requir hes been s je 2 should	Completed							24a. Was a perfori		eva	re autopsy findings ilabla prior to apletion of causa eath?
A F		Co							1 □ Ya	as 2XINo	10	Yas 2∑ No
Vita	iclan: The certificate rector, pag	Be	25. Was casa rafarred to medical axaminar?	Hoopital			011		th (Chack only on	a)		
of	hys his al di	- T	1 ☐ Yas 2 ☒ No 27, Mannar of Death		ant 2 ER/O			4 Li Nursing n	ome 5 Neside)
ion	nding fath. r: After te funer	ation	1 Matural 5 ☐ Panding 2 ☐ Accidant invastigation	28a. Data of inju (Month, Da	ly Yaar)	Tima of Injury M	28c. injur Wor 1 🗌	yat k? Yas 2 □ No	28d. Dascribe he	ow injury occur	rea	
Divis	is or Attending Patter death. I Director: After to in by the funer	Certification:	3 Suicida 6 Could not datermined	28a. Place of in	jury - At homa, fa ic. (Specify)	arm, straat, facto	ory, offica		28f. Location (Si City or Town		er or Rural	Routa Numbar,
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying P 2 Madical Exa	hysician: To the best mfner: On the basis of and mannar st	f examination ar	e, daath occurre nd/or invastigation	d at the tir	ne, date and place pinlon, daath occu	, and dua to the corred at the tima, d	ause(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)
	within To th	X	29b. Signetura end titla of certifiar			2	9c. Licans	a numbar	2	9d. Dete signe	d (Month, D	lay, Yaar)
			rashid B-	JL NO	ME)	D393	72	1	1A4 11	4 19	98
(10)		30. Nama and address of pareon who Rashid Baghai-Nai	complated cause of a	death (Item 23a) 4 Unive	(Type, Print) rsity B	lvd W	lest #324	Silver	Spring,	MD20	901
	Sta Registr		31. Data filad (Month, Day, Yaar) MAY 18	32. Pagisti	raris Signatura	Pardalli						

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Menta	I Hygiene
Certificate of Death	Reg. No.

Physician /Medical **Examiner** 1. Decedent's Nama (First, Middle, Last). ASA RICHARD

EVANS, SR.

7. Age (In yrs. last birthday)

Reg. No.

3. Time of Death 2. Date of Death

4a Fecility Name (If not Institution, give street end number)

SOUTHERN MARYLAND HOSPITAL

1□M 2□F

MAY 15 4b. City, Town, or Location of Death

CLINTON

3:51 p.m. 1998 4c. County of Death

PRINCE GEORGE'S

Funeral Director

28a-f show

Director

Funeral

þ

Completed

/ is marked other than "naturel", or items 23a or 28a-f shot traumatic event, the Modical Examiner must be notified at

I Hygiene.

permit. Peges 1 and 2 should be filled Department of Health and Mental Hygis Important: If Item 27 is marked other

Injury

Physician

/Medical

Examiner

ician and buriel-transit

physician a

peed Pes

certificate

this

After

Director:

death.

funeral

80 980 for ed by the detached

Examiner

Physician/Medical

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Completed

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Certification:

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deeth with the Maryland

Peges 1 and 2 should be filed within 72 hours efter

578-58-7019 Usual Rasidence of Decedeni 10a. State 10b. County

5. Social Security Number

10c. City, Town or Location

Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 27,1945 WASHINGTONDO

Birthplace (State or Foreign Country)

MARYLAND PRINCE GEORGE'S UPPER MARLBORO

Months

10d. Inside City Limits X□ Yes 2 □ No

10e. Street and Number

20772

10g. Citizan of What Country? USA

9727 WYMAN WAY

11. Marital Status 1 Nevar Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U,S.
Armed Forces?
1 ☐ Yas 2 No
If Yes, Giva
Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yes Z No Specify

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest greda completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC/CONSTRUCTION

16b. Kind of Business/Industry

Etementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Meiden Sumeme)

PRIVATE

STERLING EVANS

TAYLOR VIOLA

19a. Informant's Name/Relationship (Type, Print)

JOYCE EVANS - WIFE

19b. Malling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 9727 WYMAN WAY UPPER MARLBORO, MD 20772

20a. Method of Disposition

20b. Placa of Disposition (Nema of cemetery, cremetory or other pleca)

20c. Location - City or Town, State

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

Fort Lincoln Cem.

5-19 BRENTWOOD, MD

1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility MARSHALL'S FUNERAL HOME 4308 SUITLAND RD SUITLAND, MD 20746

ACUTE MI

Due to (or as a consequenca of)

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of)

Dua to (or as a consequenca of)

Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in daath) Last

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Onset and Death

1 Yes 2 No

26. Placa of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 PNatural

3 Suicide

2 Accident

4 ☐ Homicide

5 Pending investigation

6 Could not be determined

Hospital:

28a. Data of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 PER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and mannar stated.

29b. Signature and title of certifie

29d. Date signed (Month, Dey, Year)

30. Name and address of person endu

D29843 May 16, 1998

What completed cause of death (Item 23a) (Type, Print) SMHC-Emergency Dept.

S Doves 7503 Supert Rd. Clintan MD 20735

Pegistrar's Signature

Supert Signature

Supert Signature

Supert Signature

Supert Signature

Supert Signature

Supert Supert Signature

Supert Supert Signature

Supert Supert Signature

Supert Sup

State Registrar

31. Date filed (Month, Day, MAY 2 0

A. Registrar's Signaturo

DHMH 16 Rev 6/95

Box 68760 P.O.

The law requires that the death certificate be executed Division of Vital Records, Physician: or Attending

24 hours e Hospital To the Within 2
To the F 10

1 66	em#:	19a per FH G760 6/9/98			Certificate	of Death		Reg. No.		17491
Physici		1. Decedent'a Neme (First, Middle, La Leila Sexton			S		2. Date of De Month	Dey	Yeer	3. Time of Death
/Medic Examin		4e. Facility Neme (If not institution, gir				4b. City, Town	, or Location of Deet	17, 1998 h 4c. County		7:30 am
LAGITH	ici	Montgomery Gen	eral Hospi	tal		01ne			gome	
Funeral		5. Social Security Number 6. 5	Sex 7. Ag	ge (In yrs. lest	birthday) If Under 1	Year if Undar 24	Hrs. 8. Dete of Bir			⊥ y place (State or Foreign ntry)
ms 23a or 28a-f ahow constituted at a notified at		577-60-7490 Usuel Residance of Decedent	1□ M 2ሺF	88	Yrs. Months	Days Hours	Min. (Month, De Dec. 2	1. 1909		th Carolin
ahow	ō	10a. State 10b. County			own or Location					10d. Inside City Limits
or rygione's and natural, or flams 23a or 28a-f show avent, the Modical Examiner must be notified at	Director	Maryland Montgor 10e. Street and Number	mery	Oln	ey 10f. Zip C	ode		10g. Citizen of	What Cou	intry?
234		17924 Overwood I	Drive		2	0832		U.S.A	١.	
ar in	Funeral	11. Maritel Status	12. Was Decedant Armed Forces?	Ever in U,S.	13. Was Decede	nt of Hispanic Origin	? (Specify Yas or No Juerto Ricen, etc.)	- 14. Rad	ce - Amari	can Indian,
Examin	by	1 ☐ Navar Marriad 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Yaar or Dates:			No Specify:		Specif	·v:	hite
ES	P	15. Decedent's E	ducetion	1	6a. Decedent's Usual	Occupation	7070	16b. Kind of B		
important; if tem 27 is marked other than "natural", or flams 23a, any injury or other traumetic avent, the Medical Examinet must bonce.	Completed	(Specify only highest grant (S	ade completed) College (1-4or:	5+)	life. DO NOT use	done during most of retired)	working	11.0		
of, ii	ပိ	17. Father's Name (First, Middle, Last	t)		Clerk	18 Mother's	Neme (First, Middle	U.S. G		nment
5 P. C	Be c	and the state of the state of	•					, weren sumen	110/	
metic	To	Alvin Sextor			10h Mailine Address (gie Snow	or City or T	Chair	n Code)
trect		Martin Eley Son			19b. Mailing Address (
the		20e. Method of Disposition	Jon	20b. Place	17924 Over	wood Driv	e, Olney,	Marylan 20c. Location		
0.0		1 ☑ Burlal 2 ☐ Cremation 3 ☐			of Disposition (Neme etery, cremetory or oth					
Jury		4 Donation 5 Other (Special		Fort	Lincoln C		5/20/98	Brentw	ood,	Maryland
any ir		21. Signature of Funeral Service Lice	nseg /	0.4		Address of Fecility				
= 0		Maney 9.	momps.	OK	Gascn's	Funeral :	Home			
					4/39 Ba.	ltimore A	venue. Hva	attsvill	e. M	D 20781
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ician		23a. Part1. Enter the disease, or com shock, or heart failura. List only	nplicetions that ceused one ceusa on each li	the death. I	00 not enter the moda	ltimore A of dying, such as ca	venue, Hya rdiac or respiretory e	attsvill errest,	e, M	
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cal ner	Examiner	Immediate Cause (Finel disease or condition resulting in death)	e. SEPTIC	EMIA Due to (or as Y TRAC'	o not enter the moda	of dying, such as ca	venue, Hyardiac or respiretory e	attsvill		Approximete Interval Batween Onsat and Deeth HOURS
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State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director		230-20-8621	. Sex 7. Age	e (In yrs. lest t	oirthday) If Under 1 Y Yrs. Months Di	ear if Under 24 Hrs. ays Hours Min.	8. Dete of Birth (Month, Dey OCT 9,		Coun	lece (Stete or Foreign try) XANDRIA, VA
25	with the Maryland a or 28a-1 show be notified at	tor	Usuei Residence of Decedent 10a. Stete 10b. County MARYLAND PRINCE	GEORGE'S	10c. City, To CAP	wn or Location LTOL HEIGHT	TS .			11	0d. Inside City Limits
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Mary	aith and A 27 is ma or traums		19e. Informent's Neme/Relationship REBECCA FREEMAN		19	b. Mailing Address (St 220 YORKNO	reet end Number or Ru LLS DRIVE	rel Route Number CAPITOL	HEIGHTS	Stete Zip	^{Code)} 20743
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Balti	Departm Departm Importa any Inju		21. Signeture of Funeral Service Lic	1 1	Wor	22. Name end A	ddress of Fecility MAI	RSHALL'S	FUNERA	AL HON	ME OF MD
			23a. Part1. Enter the disease, or co shock, or heert feilure. List on	mplications that caused ty one cause on each lin	the death. Do	not enter the mode of	dying, such es cardled	or respiretory error	est,		Approximete Intervat Between

Physician /Medical **Examiner**

LAMBER BERNAS

Physician/Medical Examiner attending physician end of for use as the burial-transit þ tmmediete Ceuse (Final diseese or condition resulting in death)

4 Homicide

Medical Certification: To Be Completed

or Attending Physician: The law requires thet the death certificate be executed

Division of Vital Records. P.O. Box 68760.

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 3 □ Probably 4 Nonknown 1 ☐ Yaa 2 ☐ No 24e. Wes en eutopsy

1 Yes

24b. Were eutopsy findings eveilebte prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 ☐ Yes, 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA

27. Menner of Deeth 1 Neturel 5 Pending investigation 2 Accident Could not be determined 3 Suicide

1 ☐ Yes 2 ☐ No 28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

19 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end manner stated. 29a. Certifier 29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Dey, Yeer)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD 20912

State Registrar

completaly

Registrer's Signature

To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A

是一个人,我们的一个人,一个人的一个人的一个人,他们就

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 01:05 Pm Month **Physician** JOHN GOVAN 1998 13, 1998 4c. County of Death MAY /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) Examiner LANHAM DOCTOR'S PRINCE GEORGES COMMUNITY HOSPITAL If Under 1 Yeer If Under 24 Hrs. 5 Social Security Number 8. Date of Birth (Month, Dev. Year) 1902 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Hours 11XM 2□ F Months Min 245-14-3125 October 13. South Carolina Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10e. Stete 10b. County r 28a-f show a notified at XYas 2 No Directo Maryland Prince Georges Greenbelt. 10e. Street end Number 7010 Greenbelt Road 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23e or edical Examiner must be Greenbelt Nursing & Rehabilitation Center 20770 United States Jamm. Pages 1 and 2 should be filed within 72 hours after death to Desirment of Haalth and Mental Hygiene.

Important: If item 27 is marked other than "natural", or itema 23s, any Injury or other traumatic event, the Medical Example Injury. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Maritel Stetus Bleck, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) SElf-Employed 12th grade Automotive Consignment Dealer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be John Govan Martha Cheeseboro 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mack Daniel Govan (son) 805 Painter Place, Capitol Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Brentwood 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery/May 18,1998 (Bladensburg)Maryland 22. Name end Address of Fecility Robert G. Mason Funeral Home, Inc 21. Signature of Pareral Service Licensee 1661 Good Hope Road, S.E.; Washington, D.C. 20020 23a. Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical HYPERTENSIVE ARTERIOSCHEROTIC CARDIOVASCULAR DISEARE Examiner Due to (or es e consequence of) Examiner certificata be axecuted physicien end the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of): ettending pl The law requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? by the tached 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS Division of Vital Records, þ been sig 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminer? Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 2 1♥ Yes 2 No 3 DOA After this 28c. Injury et Work? 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: Hospital or Attending Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Ptece of Injury - At home, ferm, street, factory, office building, etc. (Specify) after 4 Homicide 24 hours at Funeral D letaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the end manner as stated. 29a. Certifier edicai (Check only one) eminetion end/or investigation, to my opinton, deeth occurred at the time, date and place, and due to the cause(s) To the Vithin 2 29b. Signature and title of certifier 29d. Date aigned (Month, Day, Year) VME MAY 13, 1998 (Item 23a) (Type, Print) 30. Name and address of person who ompleted cause of A HOSPITAL PRIVE CHEVERLY, MARYLAND 20785 3001 MARIO GOLLE egistrar's Signeture 31. Dete filed (Month, Day, Year) State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene O O

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State Registrar

501 NORTH FREDERICK AVE., GAITHERSBURG, MD. 20877 31. Date filed (Month, Day, Year) MAY 1 8 1998

EDWARD G. MOVIUS, M.D.

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